



State Medical Board of Ohio

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June 13, 2007

Venu Gopal Menon, M.D.
610 Boxwood Court
Troy, OH 45373

Dear Doctor Menon:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of Gretchen L. Petrucci, Esq., Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on June 13, 2007, including motions approving and confirming the Report and Recommendation as the Findings and Order of the State Medical Board of Ohio.

Section 119.12, Ohio Revised Code, may authorize an appeal from this Order. Such an appeal must be taken to the Franklin County Court of Common Pleas.

Such an appeal setting forth the Order appealed from and the grounds of the appeal must be commenced by the filing of an original Notice of Appeal with the State Medical Board of Ohio and a copy of the Notice of Appeal with the Franklin County Court of Common Pleas. Any such appeal must be filed within fifteen (15) days after the mailing of this notice and in accordance with the requirements of Section 119.12, Ohio Revised Code.

THE STATE MEDICAL BOARD OF OHIO

Lance A. Talmage, M.D.
Secretary

LAT:jam
Enclosures

REGISTERED MAIL NO. 91 7108 2133 3931 8317 2996
RETURN RECEIPT REQUESTED

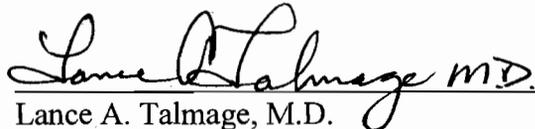
Cc: Elizabeth Y. Collis, Esq.
CERTIFIED MAIL NO. 91 7108 2133 3931 8317 3009
RETURN RECEIPT REQUESTED

Mailed 6-15-07

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation of Gretchen L. Petrucci, State Medical Board Attorney Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on June 13, 2007, including motions approving and confirming the Findings of Fact, Conclusions and Proposed Order of the Hearing Examiner as the Findings and Order of the State Medical Board of Ohio; constitute a true and complete copy of the Findings and Order of the State Medical Board in the matter of Venu Gopal Menon, M.D., as it appears in the Journal of the State Medical Board of Ohio.

This certification is made by authority of the State Medical Board of Ohio and in its behalf.



Lance A. Talmage, M.D.
Secretary

(SEAL)

June 13, 2007

Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

*

*

VENU GOPAL MENON, M.D.

*

ENTRY OF ORDER

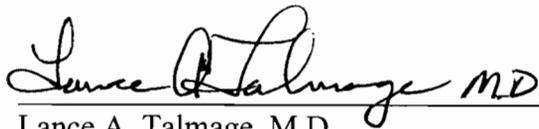
This matter came on for consideration before the State Medical Board of Ohio on June 13, 2007.

Upon the Report and Recommendation of Gretchen L. Petrucci, State Medical Board Attorney Hearing Examiner, designated in this Matter pursuant to R.C. 4731.23, a true copy of which Report and Recommendation is attached hereto and incorporated herein, and upon the approval and confirmation by vote of the Board on the above date, the following Order is hereby entered on the Journal of the State Medical Board of Ohio for the above date.

It is hereby ORDERED that:

PERMANENT REVOCATION: The certificate of Venu Gopal Menon, M.D., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED.

This Order shall become effective immediately upon the mailing of notification of approval by the Board.


Lance A. Talmage, M.D.

Secretary

(SEAL)

June 13, 2007

Date

STATE MEDICAL BOARD
OF OHIO

2007 MAY 16 A 10: 19

**REPORT AND RECOMMENDATION
IN THE CONSOLIDATED MATTERS OF VENU GOPAL MENON, M.D.**

The Consolidated Matters of Venu Gopal Menon, M.D., were heard by Gretchen L. Petrucci, Hearing Examiner for the State Medical Board of Ohio, on January 26 and February 26, 2007.

INTRODUCTION

I. Basis for Hearing

- A. By letter dated August 10, 2005, the State Medical Board of Ohio [Board] notified Venu Gopal Menon, M.D., that it had proposed to take disciplinary action against his certificate to practice medicine and surgery in Ohio. The Board's proposed action was based on two allegations. First, the Board alleged that Dr. Menon had not complied with several terms, conditions and limitations imposed by the Board in an Order dated May 14, 2003 [2003 Board Order]. Specifically, the Board alleged that Dr. Menon had not: (1) provided certain quarterly declarations when due, (2) ensured that his monitoring physician provided quarterly reports when due, and (3) notified the Board when action was taken against his license by the Board of Medical Examiners of the State of Iowa [Iowa Board] in September 2004 and by the Department of Health and Human Services Regulation and Licensure for the State of Nebraska [Nebraska Board] in April 2005. The Board alleged that these acts, conduct, and/or omissions constitute a "[v]iolation of the conditions of limitation placed by the board upon a certificate to practice," as that language is used in Section 4731.22(B)(15), Ohio Revised Code.

Second, the Board alleged that Dr. Menon entered into a settlement agreement that was adopted by the Nebraska Board in April 2005 and, as a result, Dr. Menon surrendered his Nebraska license for a minimum period of two years. The Board further alleged that the Nebraska April 2005 action constitutes "[a]ny of the following actions taken by the agency responsible for regulating the practice of medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or the limited branches of medicine in another jurisdiction, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual's license to practice; acceptance of an individual's license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand," as that language is used in Section 4731.22(B)(22), Ohio Revised Code.

- Finally, the Board notified Dr. Menon of his right to request a hearing concerning the Board's August 2005 allegations. (State's Exhibit 1A)
- B. No request for a hearing was received. On December 14, 2005, the Board issued an Order permanently revoking Dr. Menon's Ohio certificate. Dr. Menon appealed that decision on service-related grounds. On October 10, 2006, the Franklin County Court of Common Pleas, upon agreement of the parties, remanded the matter to the Board "for the purpose of serving Dr. Menon with a copy of the August 10, 2005, Notice of Opportunity for Hearing by means of certified mail and to provide Dr. Menon with the opportunity to request and obtain a hearing in accordance with [Ohio Revised Code] Chapter 119, on the underlying administrative matter." The Board re-mailed the August 10, 2005, Notice of Opportunity for Hearing on October 23, 2006. (State's Exhibits 1A, 1K)
- C. By letter dated November 9, 2006, the Board also notified Dr. Menon that it had proposed to take additional disciplinary action against his certificate to practice medicine and surgery in Ohio. This proposed action was based on the allegations that Dr. Menon had again not complied with several terms, conditions, and limitations imposed by the 2003 Board Order because he had not: (1) provided a quarterly declaration by November 1, 2005; (2) ensured that his monitoring physician provided a quarterly report by November 1, 2005; and (3) notified the Board when action was taken against his certificate by the Arizona Medical Board [Arizona Board] in January 2005. The Board alleged that these additional acts, conduct, and/or omissions also constitute a "[v]iolation of the conditions of limitation placed by the board upon a certificate to practice," as that language is used in Section 4731.22(B)(15), Ohio Revised Code. (State's Exhibit 1B)
- D. By letter filed on November 13, 2006, Dr. Menon's counsel requested a hearing on the allegations raised in the August 10, 2005, and the November 9, 2006, Notices of Opportunity for Hearing. (State's Exhibit 1C)
- E. In November 2006, the Board reinstated Dr. Menon's Ohio certificate subject to the terms of the 2003 Board Order, in effect rescinding its revocation order of December 14, 2005. (Hearing Transcript Volume I at 163, 166; Ohio E-License Center, May 14, 2007 <<https://license.ohio.gov/Lookup/SearchDetail.asp?ContactIdnt=3055714&DivisionIdnt=78&Type=L>>)
- F. By Entry dated January 18, 2007, the matters in the August 10, 2005, and the November 9, 2006, Notices of Opportunity for Hearing were consolidated. (State's Exhibit 1I)

II. Appearances at the Hearing

- A. On behalf of the State of Ohio: Marc E. Dann, Attorney General, by Barbara J. Pfeiffer, Assistant Attorney General.

B. On behalf of the Respondent: Elizabeth Y. Collis, Esq.

EVIDENCE EXAMINED

I. Testimony Heard

Venu G. Menon, M.D.
Antony T. Jacob, M.D.
Danielle Bickers

II. Exhibits Examined

A. State's Exhibits

State's Exhibits 1A through 1L: Procedural Exhibits.

State's Exhibit 2: Copies of documents maintained by the Board in the *Matter of Venu G. Menon, M.D.* [*Menon I*].

State's Exhibit 3: Certified copy of documents maintained by the Iowa Board in the *Matter of the Statement of Charges Against Venu G. Menon, M.D.*, File No. 02-02-780.

State's Exhibit 4: Certified copy of documents maintained by the Nebraska Board in *State of Nebraska ex rel. etc. v. Venu G. Menon, M.D.*, Case No. 69-050354.

State's Exhibit 5: Certified copy of the letter of reprimand by the Arizona Board in the *Matter of Venu G. Menon, M.D.*, Case No. MD-03-0684A, and of Dr. Menon's physician profile as of August 8, 2005, from the Arizona Board's website.

State's Exhibit 6: June 13, 2003, letter from Danielle Bickers to Dr. Menon and enclosed Board Order Compliance Review Form.

State's Exhibit 7: May 30, 2005, Declaration of Compliance by Dr. Menon.

State's Exhibit 8: April 30, 2004, letter from Antony T. Jacob, M.D., to Ms. Bickers.

State's Exhibit 9: September 3, 2004, letter from Dr. Jacob to Ms. Bickers.

State's Exhibit 10: December 16, 2004, letter from Dr. Jacob to Ms. Bickers.

State's Exhibit 11: September 13, 2005, letter from Dr. Jacob to Ms. Bickers.

State's Exhibit 12: August 13, 2003, Declaration of Compliance by Dr. Menon.

State's Exhibit 13: April 7, 2004, letter from Ms. Bickers to Dr. Jacob.

B. Respondent's Exhibits

Respondent's Exhibit A: February 11, 2005, letter from Dr. Jacob to Ms. Bickers.

Respondent's Exhibit B: May 13, 2005, letter from Dr. Jacob to Ms. Bickers.

Respondent's Exhibit C: August 12, 2005, letter from Dr. Jacob to Ms. Bickers.

Respondent's Exhibit E: March 12, 2002, letter from Jane M. Eskildsen, M.D.¹

Respondent's Exhibit F: January 22, 2007, letter from Walter K. Eskildsen, M.D., fka Jane M. Eskildsen, M.D.

Respondent's Exhibit G: February 25, 2002, letter from Richard W. Slovek, M.D.

Respondent's Exhibit H: December 11, 2002, letter from the Board to Dr. Menon and enclosed order from the Oklahoma State Board of Medical Licensure and Supervision in the *Matter of the Application of Venu Gopal Menon for Reinstatement of Medical License No. 12923*, Application No. 12923.

C. Board Exhibit

Board Exhibit A: Copy of the Board's December 14, 2005, Findings, Order and Journal Entry in the *Matter of Venu G. Menon, M.D. [Menon II]*.

PROCEDURAL MATTERS

After completion of the hearing, the Hearing Examiner realized that the record did not contain documentary evidence of the Board's December 14, 2005, Order permanently revoking Dr. Menon's Ohio certificate or the Board's November 2006 reinstatement of Dr. Menon's Ohio certificate after the ruling of the Common Pleas Court. During a conference call on May 8, 2007, counsel for the parties agreed to reopening the record for the purpose of admitting those additional documents. Thereafter, counsel for Respondent attempted to locate the reinstatement decision. On May 10, 2007, the examiner was informed that a copy of the Board's November 2006, decision to reinstate Dr. Menon's Ohio certificate or other documentary evidence of the reinstatement could not be located. It is not disputed, however, that Dr. Menon's Ohio certificate was reinstated by the Board in 2006. On May 14, 2007, the Hearing Examiner obtained a copy of the Board's December 14, 2005, Order, marked it as Board Exhibit A, reopened the record and admitted that additional exhibit. The record closed on May 14, 2007.

¹An exhibit identified as Respondent's Exhibit D was not marked or admitted.

SUMMARY OF THE EVIDENCE

All exhibits and transcripts of testimony, even if not specifically mentioned, were thoroughly reviewed and considered by the Hearing Examiner prior to preparing this Report and Recommendation.

Background

1. Venu Gopal Menon, M.D., graduated from the All India Institute of Medical Services and then entered the Indian Army for several years. He worked in England, Norway, Holland and Sweden and then came to the United States in 1975. (State's Exhibit [St. Ex.] 2)
2. Dr. Menon completed two years of anesthesiology residency in 1977. Next, he joined the United States Navy and worked in various parts of the United States. In 1981, he left active duty and took a position with the Nashville Veterans Administration Hospital for six to nine months. After that, he worked simultaneously at the University of Iowa and a Veterans Administration Hospital. In 1986, he took a private practice position in Troy, Ohio, providing anesthesiology services. He held privileges at Stouder Memorial Hospital [Stouder] and Piqua Memorial Medical Center [Piqua]. (St. Ex. 2, Hearing Transcript Volume I [Tr. I] at 162)
3. Dr. Menon's Stouder privileges were terminated on October 26, 1994, based upon "quality of care concerns regarding the manner in which Dr. Menon completed medical records; longstanding and continuing concerns regarding Dr. Menon's lack [of] availability during epidural anesthesia and on-call coverage." Dr. Menon was also terminated from Piqua on November 24, 1998, based upon quality of care concerns. After a period of unemployment, Dr. Menon provided locum tenens work in Iowa, Florida, Arizona, and Nebraska. The position in Nebraska was converted into a permanent position at Community Hospital in McCook, Nebraska. Dr. Menon remained employed at Community Hospital until February 2002, when he was discharged.² (St. Ex. 2 at 14-15; Tr. I at 150, 160-161)

Dr. Menon then resumed locum tenens work in Ohio and Nebraska for a brief period of time. In September 2002, he became employed at the Dayton Outpatient Center [DOC] providing anesthesia and pain management services. He remained employed there until January 2006, when he was terminated because the Board had revoked Dr. Menon's Ohio certificate in December 2005. A more detailed summary of Dr. Menon's medical training and employment history is set forth in the Board's May 13, 2003, decision in *Menon I*. (St. Ex. 2; Tr. I at 84-85, 140, 148-149)

²In the summary of evidence in the Report and Recommendation from this Board's previous *Matter of Venu G. Menon, M.D. [Menon I]* and at the hearing in these consolidated matters, Dr. Menon testified that he was discharged from Community Hospital in McCook, Nebraska, due to budget reductions. However, the allegations made by the Nebraska Board, and admitted by Dr. Menon in that state's 2005 disciplinary proceeding against Dr. Menon indicate that Dr. Menon was discharged from Community Hospital in McCook, Nebraska, due to his substandard care and treatment practices. (St. Ex. 2, at 19; St. Ex. 4 at 9; Tr. I at 151-152)

4. Dr. Menon has held licenses in Arizona, Florida, Iowa, Nebraska, Ohio and Oklahoma. Each of those states has conducted investigations of Dr. Menon and, as of the time of the hearing in these consolidated matters, all except Florida have taken disciplinary action against Dr. Menon. He currently holds active medical licenses in Arizona and Florida, and has an active certificate in Ohio that is subject to probationary terms, conditions, and limitations. (Tr. I at 84, 106, 162-163, 167-168)

Board's 2003 Disciplinary Action – *Menon I*

5. In December 2002, this Board notified Dr. Menon that it had proposed to take disciplinary action against his certificate to practice medicine and surgery in Ohio. Following an evidentiary hearing, the Board issued a decision in *Menon I* on May 14, 2003. The Board concluded that, in September 2002, the Oklahoma State Board of Medical Licensure and Supervision [Oklahoma Board] denied Dr. Menon's request to reinstate his medical license in that state because Dr. Menon had submitted false information on his reinstatement application and he had previously lost privileges at two hospitals in Ohio based upon quality of care issues. As a result of the Oklahoma Board action, this Board suspended Dr. Menon's Ohio certificate for a period of one year, stayed that suspension, and imposed a probationary period of at least three years. (St. Ex. 2; Respondent's Exhibit [Resp. Ex.] H)

Additionally, this Board required Dr. Menon to: (a) make personal appearances; (b) provide quarterly declarations of compliance with the Order's probationary terms, conditions, and limitations; (c) attend a medical records course; (d) submit a plan of practice in Ohio under a supervised, structured environment; (e) submit the name of a monitoring physician [MP] who would monitor Dr. Menon and provide reports to the Board; (f) ensure that those MP reports are timely provided to the Board; and (g) notify the Board when any action is taken against his certificate to practice in any other state. The Board directed Dr. Menon to notify the following persons or entities of the Board's 2003 decision: (a) his current and future health care employers; (b) all hospitals at which he holds or applies for privileges or appointments; and (c) other state licensing agencies in which he currently holds a professional license, where he applies for reinstatement or restoration of a professional license, or where he applies for a new professional license. (St. Ex. 2)

Post-2003 Board Order Compliance – Quarterly Declarations of Compliance

6. Danielle Bickers, Compliance Supervisor at the Board, testified that she monitored Dr. Menon's compliance with the terms of the 2003 Board Order. To assist Dr. Menon, she sent him a checklist in June 2003. The checklist included a suggested calendaring of the documentation deadlines, along with an explanation of those deadlines. Further, Ms. Bickers provided Dr. Menon with a sample compliance declaration form. Ms. Bickers acknowledged that she was not aware whether Dr. Menon received the checklist and she did not meet with Dr. Menon to explain the requirements of the 2003 Board Order. Dr. Menon testified that he never received Ms. Bickers' June 2003 letter or checklist. However, he received the compliance declaration form when he made his first, post-Order

appearance before the Board in August 2003. Dr. Menon testified that he mailed that declaration of compliance to the Board afterward. (Tr. I at 23-27, 41-42, 88, 128-131; St. Exs. 6, 12)

7. As noted, the 2003 Board Order required Dr. Menon to submit quarterly declarations of his compliance with the Order's probationary terms, conditions, and limitations. The first quarterly declaration was due on August 1, 2003, and the subsequent declarations were due every three months thereafter. Ms. Bickers testified that Dr. Menon provided many declarations of compliance. Also, she testified that Dr. Menon failed to submit the quarterly declarations that were due in February, August and November 2005; and failed to timely submit the May 2005 declaration. Ms. Bickers did not recall and had no notes indicating whether she spoke with Dr. Menon about the timeliness of his declarations. (St. Exs. 2, 6; Tr. I at 25-26, 33-34, 56-57)

Ms. Bickers noted that Dr. Menon could have verified receipt of his quarterly declarations by sending them via certified mail, via facsimile with a confirmation, or by calling her directly. She recalled no such contact by Dr. Menon. (Tr. I at 59, 68)

8. Below is a summary of Dr. Menon's declaration activities pursuant to the 2003 Board Order:

Quarterly Declarations

Declaration Due Date	Date of Declaration	Date that the Board Received the Declaration
8/1/03	8/13/03	8/13/03 or shortly thereafter
11/1/03	12/1/03	12/2/03
2/1/04	2/24/04	2/27/04
5/1/04	4/24/04	4/27/04
8/1/04		Not received ³
11/1/04	12/12/04	12/14/04
2/1/05		Not received
5/1/05	5/30/05	6/6/05
8/1/05		Not received
11/1/05		Not received

(Tr. I at 30-34, 54-56; St. Exs. 7, 12)

9. Dr. Menon testified that he understood that he was required by the 2003 Board Order to submit quarterly declarations of compliance to the Board. He also stated that he sent his quarterly declarations every three months and none of the mailings were returned to him.

³The Board has not alleged in either the August 2005 Notice of Opportunity for Hearing or the November 2006 Notice of Opportunity for Hearing that Dr. Menon was not in compliance with the 2003 Board Order because he failed to provide a declaration of compliance by the August 1, 2004 due date. Thus, his conduct with respect to an August 2004 declaration of compliance is *not* at issue in these consolidated matters. The information is included in this chart in order to provide a full summary of activity related to the declarations of compliance from the effective date of the May 2003 Order through 2005.

He acknowledged that he did not know the specific deadlines for the declarations, he did not keep any copies of his declarations, and he did not contact the Board to determine if his declarations were received. Dr. Menon further stated that he received no notice or telephone call informing him that his quarterly declarations were late. (Tr. I at 87-92, 133-134)

In particular, Dr. Menon testified:

- Q. Okay. Now, the Board has alleged that there were certain months that you submitted your documents to the Board late, your quarterly documents. According to Miss Bickers' testimony, what would have been the second report that you submitted to the Board was due on November 1st, 2003, and that the Board received a report from you on December the 1st, 2003, about a month late. Did you know that report was due in November?
- A. [By Dr. Menon] I didn't know. Every three months I just signed the paper and drop it in the mailbox. I don't really look into the dates.
- Q. So in your mind, did you realize that documentation was going to be due at August 1st, November 1st, February and May?
- A. [By Dr. Menon] I didn't know.

(Tr. I at 89-90)

Post-2003 Board Order Compliance – Quarterly Monitoring Physician [MP] Reports

10. The 2003 Board Order also required that, upon Board approval of a MP for Dr. Menon, the MP must, among other things, submit quarterly reports. Moreover, the 2003 Board Order stated: "Dr. Menon shall ensure that the [MP] reports are forwarded to the Board on a quarterly basis and are received in the Board's offices no later than the due date for Dr. Menon's quarterly declaration." In February 2004, the Board permitted Antony Jacob, M.D., to act as Dr. Menon's MP. Ms. Bickers noted that the delay in selecting a MP was not because Dr. Menon did not comply with the Board's 2003 requirement to propose a MP. Rather, the delay occurred because there was discussion between the Board and Dr. Menon as to who would be an appropriate MP. (Tr. I at 35, 68-70, 129; St. Ex. 2)
11. Dr. Jacob practices physical medicine, and rehabilitation and electrodiagnostic medicine in Dayton, Ohio. He was familiar with Dr. Menon because he conducted electrodiagnostic testing and provided some pain management services at the DOC at the same time Dr. Menon worked there. Dr. Jacob testified that, as Dr. Menon's MP, he needed to: monitor handwriting; review charts for readability, diagnoses, and treatment plans; and generate reports. (Hearing Transcript Volume II [Tr. II] at 180-183, 194-195)

12. Upon approval of Dr. Menon's MP, Ms. Bickers testified she sent an introductory letter to Dr. Jacob that outlined his responsibilities as MP and set forth the initial report due date of May 1, 2004. Ms. Bickers stated that Dr. Jacob provided several MP reports, but failed to submit MP reports for February, May, August and November 2005. Ms. Bickers did not recall and had no notes indicating whether she spoke with Dr. Menon or Dr. Jacob about the timeliness of the MP reports. She also stated that the reports she received directly from Dr. Jacob did not contain original signatures; rather, the reports she received were photocopies. (St. Exs. 2, 13; Tr. I at 38, 44-46, 65-66, 72)

Dr. Jacob testified that he provided quarterly MP reports from the initial due date of May 1, 2004, through September 2005. (Tr. II at 184, 187, 189, 199-202; St. Exs. 8-11; Resp. Exs. A-C)

13. Below is a summary of the MP report activity pursuant to the 2003 Board Order from the implementation date of MP requirements through 2005:

Monitoring Physician Reports

MP Report Due Date	Date of MP Report	Date that the Board Received the MP Report
5/1/04	4/30/04	5/3/04
8/1/04	9/3/04	9/7/04
11/1/04	12/16/04	12/20/04
2/1/05	2/11/05	Duplicate copy on 1/26/06
5/1/05	5/13/05	Duplicate copy on 1/26/06
8/1/05	8/12/05	Duplicate copy on 1/26/06
	9/13/05	9/14/05
11/1/05	None	N/A

(Tr. I at 35-38, 48-53; Tr. II at 184, 187, 189, 199-202; St. Exs. 8-11; Resp. Exs. A-C)

14. Dr. Menon and Dr. Jacob described their monitoring activities. Dr. Jacob testified that, usually on Thursdays, he would go to the DOC and, before seeing his own patients, he would meet with Dr. Menon for 15 to 20 minutes. At that time, Dr. Jacob would review eight to ten charts that were already selected and ready for him, and then he would discuss his findings with Dr. Menon. Dr. Jacob acknowledged that all of his MP reports stated that he had reviewed ten patient charts, although he testified that he had actually reviewed between eight to ten patient charts. Dr. Jacob could not identify which reports were based upon a review of eight charts, as opposed to ten charts. Dr. Jacob did not find any deficiencies with Dr. Menon's practice. Dr. Jacob explained that, since he was at the DOC only for a few limited hours, he had Dr. Menon's office select the charts for him to review. (Tr. I at 93, 147-148; Tr. II at 182-183, 187-188, 193-196, 201-203, 213-215, 223)⁴

⁴Ms. Bickers stated that the MP reports she received from Dr. Jacobs were acceptable in content, but she noted that they were largely the same report. In particular, Ms. Bickers testified, "[i]t looks to me like it's just the same report generated each time and maybe not the review being done that we would have liked to have seen done, if that makes sense." (Tr. I at 71)

15. Dr. Jacob explained the process he used to generate his MP reports. He noted that his first MP report was dictated by him and then typed by his secretary. The subsequent MP reports were created by electronically updating the preceding report. Dr. Jacob would proof the report and then his secretary would print and mail the report to the Board. Dr. Jacob kept no notes pertaining to the monitoring of Dr. Menon's practice. He did not send copies of the MP reports to Dr. Menon, and he did not keep hard copies of his reports. (Tr. II at 184-186, 212, 220-221)
16. When Dr. Menon's former office switched to electronic patient charts at the end of summer 2005, Dr. Jacob concluded that there was no need for him to review Dr. Menon's patient charts. Dr. Jacob stated that he actually stopped reviewing Dr. Menon's patient charts sometime in July, August or September 2005. He further stated that he did not notify Dr. Menon or the Board that he ceased that responsibility. Dr. Jacob stated that he was not told by Dr. Menon or the Board to cease his MP duties and he did not ask to be relieved of those duties. Dr. Jacob provided no MP reports after September 2005. (Tr. II at 189-191, 203-204, 207-210, 213)
17. Dr. Menon did not inquire as to why Dr. Jacob stopped reviewing patient charts when his probation period had not yet expired. Dr. Menon also stated that he: (a) did not write down any of the dates that he met with Dr. Jacob, (b) does not remember any of the meeting dates, (c) did not receive copies of Dr. Jacob's MP reports, and (d) did not confirm with Dr. Jacob that the MP reports were sent in. Dr. Menon testified, however, that Dr. Jacob told him of his findings and that he was sending the MP reports to the Board. Also, Dr. Menon indicated that he did not receive any communications from the Board that the MP reports were not being timely submitted. He further testified that the last time he spoke with Dr. Jacob was in 2005. Dr. Menon also stated his belief that the MP reports were confidential and he was not permitted to see them. (Tr. I at 93-94, 132-133, 136, 147, 165)
18. Dr. Menon's counsel contacted Dr. Jacob in January 2006, after the Board revoked Dr. Menon's Ohio certificate based in part on the allegation that three MP reports were not provided to the Board when due. Dr. Jacob forwarded copies of three MP reports. Those three MP reports [collectively, the missing reports] were dated February 11, May 13, and August 12, 2005. Dr. Jacob explained that his secretary reprinted those three missing reports from her computer and that, since he had not kept copies of the original versions, he might have signed them again in January 2006. (Resp. Exs. A-C; Tr. II at 225)
19. Ms. Bickers commented that, like the other MP reports, the missing reports were largely the same in content. However, Ms. Bickers noted that, in comparing these missing reports with those she had received previously, something struck her. Specifically, Ms. Bickers testified:

They appear to be the same report that were – reports that were turned in prior with the exception of the first line, and I – when I did review these reports, when the assistant attorney general's office provided them to the enforcement

attorney and I looked at them, the thing that kind of stood out was, again, that first line, “This is the first report,” “This is the second report.” Well, the only report that I received in 2005 was the September 13th, 2005, report from Dr. Jacob, and it’s the only one that says, “This is the fourth report to the Board” as opposed to “This is the fourth report of 2005,” which struck me as odd because that’s the only report that I had, and yet these other reports were supposedly sent to the Board.

(Tr. I at 71-72) Essentially, Ms. Bickers stated that the three missing reports “open” differently from the reports Ms. Bickers had received previously and that difference struck her as “odd.”

20. The following are the opening statements of each MP report:

Date of the Originally Received MP Reports	Opening Statement
April 30, 2004	“This is the first report to the Board on the conformance of Dr. Venu G. Menon * * * ”
September 3, 2004	“This is the second report to the Board on the conformance of Dr. Venu G. Menon * * * ”
December 16, 2004	“This is the third report to the Board on the conformance of Dr. Venu G. Menon * * * ”
September 13, 2005	“This is the fourth report to the Board on the conformance of Dr. Venu G. Menon * * * ”
Date of Missing Reports	Opening Statement
February 11, 2005	“This is the first report of 2005 to the Board on the conformance of Dr. Venu G. Menon * * * ”
May 13, 2005	“This is the second report of 2005 to the Board on the conformance of Dr. Venu G. Menon * * * ”
August 12, 2005	“This is the third report of 2005 to the Board on the conformance of Dr. Venu G. Menon * * * ”

(St. Exs. 8-11; Resp. Exs. A-C)

21. Dr. Jacob identified three errors in the content of his August and September 2005 MP reports. However, his testimony was inconsistent in certain respects. The first error that Dr. Jacob identified was the date of his August 12, 2005, report. At one point, Dr. Jacob testified that the August 2005 report was intended to meet the August 1, 2005, deadline. However, he also testified that the date should have been mid-September 2005. The second error that Dr. Jacob identified was the date of his September 13, 2005, report. Dr. Jacob testified that the date should have been in August 2005 and, yet also, stated that the September 2005 report should have been dated for sometime after September 2005. The third error that Dr. Jacob identified was that the opening to his August 2005 report should have stated that it was the “fourth report.” (Tr. II at 191-193, 204-207, 209, 211, 216-219, 224)

Other States' Actions against Dr. Menon after the 2003 Board Order

22. On September 15, 2004, the Iowa Board entered an order imposing an indefinite suspension against Dr. Menon, requiring that he successfully complete: (a) an ethics course, (b) a competency evaluation at the Center for Personalized Education for Physicians [CPEP], and (c) any CPEP educational program. The order was based on the action taken by the Oklahoma Board in September 2002. Dr. Menon did not appear at the administrative hearing because he was taking a "serious course in anesthesiology at that time." (St. Ex. 3; Tr. I at 95)
23. On January 4, 2005, the Arizona Board issued a letter of reprimand against Dr. Menon, based on the action taken by the Oklahoma Board in September 2002 and by this Board in *Menon I*. Dr. Menon appeared before the Arizona Board without counsel. (St. Ex. 5; Tr. I at 110, 127)
24. On April 6, 2005, the Nebraska Board issued an order accepting a settlement agreement signed by Dr. Menon and the State of Nebraska, pursuant to which Dr. Menon agreed to surrender his Nebraska medical license for at least two years. Dr. Menon admitted the allegations made by the State of Nebraska. Dr. Menon did not have counsel for that proceeding. (St. Ex. 4; Tr. I at 100)

The allegations made by the State of Nebraska were based upon Dr. Menon's activities while working at Community Hospital in McCook, Nebraska, from approximately April 2000 to February 2002. Community Hospital is a 43-bed hospital providing general surgery, orthopedic surgery, obstetrics, and gynecology services. Dr. Menon was the only anesthesiologist at the hospital, but a nurse anesthetist was also employed there. (Tr. I at 150-151)

25. The following are the 12 substantive allegations made by the State of Nebraska, and Dr. Menon's testimony at this hearing in response to some of those allegations.
 - Nebraska Allegation 6: "On or about July 6, 2001, between approximately 12:15 p.m. and approximately 2:00 p.m., [Dr. Menon] attempted to intubate patient G.R. for administration of general anesthesia eight (8) to twelve (12) times without success. During the intubation attempts, [Dr. Menon] ordered Nurse S.B. to draw-up and administer numerous doses of succinylcholine, a paralytic agent. During the failed attempts, patient G.R.'s oxygen saturation levels dropped to between 30% and 40%. [Dr. Menon] failed to chart the orders to Nurse S.B. for the administration of succinylcholine, and failed to chart all oxygen saturation levels." (St. Ex. 4 at 7)

Response during this hearing: Dr. Menon stated that he did not chart the orders for succinylcholine at the time he was trying to intubate the patient, but that he did chart the orders once the patient was put on a spinal anesthesia. Further, he testified that he did not chart all the oxygen saturation levels of that patient and,

in particular, stated that “Oxygen saturation, that changes very often; but I didn’t even know then what it was.” (Tr. I at 99, 116-118)

- Nebraska Allegation 7: “Between approximately April 2000 to approximately February 2002, [Dr. Menon] prescribed antibiotic medication for a patient without documenting in the patient’s chart the medications prescribed or the purpose for which they were prescribed. [Dr. Menon] admitted in interviews conducted on September 10, 2003 and September 15, 2003, that he provided his girlfriend antibiotics by using the hospital prescription pads and that he did not keep any records of the medical care he provided to his girlfriend.” (St. Ex. 4 at 7)

Response during this hearing: Dr. Menon stated that he did prescribe an antibiotic without documenting the medication. Dr. Menon stated that the antibiotic was for his “cleaning person” who was suffering from a cough and cold. Dr. Menon stated that this person, a male, was not his patient. Dr. Menon explained that the gentleman could not afford to see his doctor and Dr. Menon did not “make it a habit” to prescribe medications for people who were not his patients. (Tr. I at 119, 154)

- Nebraska Allegation 8: “Between approximately April 2000 to approximately August 2001, [Dr. Menon] provided anesthesia services on numerous occasions for cataract procedures. In interviews of [Dr. Menon] conducted on September 10, 2003 and September 15, 2003, [Dr. Menon] admitted to re-using the same syringe on four (4) to five (5) patients each day in a three (3) to four (4) day time period. According to [Dr. Menon], he continued the practice of reusing syringes on different patients until he was told by Nurse B. to stop.” (St. Ex. 4 at 7)

Response during this hearing: Dr. Menon disagreed that he reused syringes on different patients over the course of several days. He stated that, instead, it occurred on only one day. He further testified that the same syringe could be reused because there was still medication in it, but the needle was changed each time. Dr. Menon testified that the medication was injected into the intravenous tube (not into the patient directly) and “there’s no way of contamination at all.” (Tr. I at 119-120, 155-156)

- Nebraska Allegation 9: “Between approximately April 2000 to approximately February 2002, [Dr. Menon] failed to label each syringe he used to administer different medications during any given procedure. [Dr. Menon] admitted in interviews conducted on September 10, 2003 and September 15, 2003, that he regularly did not label the different syringes he used in each surgical case.” (St. Ex. 4 at 7-8)

Response during this hearing: Dr. Menon agreed that this occurred, stating that there were no labels available to use at that time. (Tr. I at 120)

- Nebraska Allegation 10: “Between approximately April 2000 to approximately February 2002, [Dr. Menon] was observed by OR staff members, on more than one occasion, leaving a patient under his care, while the patient was under anesthesia, to wit:
 - “A. On or about May 30, 2001, a surgical procedure had to be stopped when a patient started moving around. At the time, [Dr. Menon] was in the hallway outside the operating room talking with a student. [Dr. Menon] had to be asked to return to the operating room to administer more sedation so the surgical procedure could be completed.
 - “B. On other occasions, after administering anesthesia, [Dr. Menon] left his patients in the operating room to drink coffee outside the operating room.”

(St. Ex. 4 at 8)

Response during this hearing: Dr. Menon did not agree that allegation 10(A) had occurred, but partially acknowledged that allegation 10(B) had occurred. He stated that he usually moved around within the operating room when local anesthesia was used, but would remain at the head of the table when general anesthesia was given. (Tr. I at 121-122, 157)

- Nebraska Allegation 11: “On approximately September 10, 2003 and approximately September 15, 2003, during interviews with a Department investigator, [Dr. Menon] admitted to being approximately 20 feet away from patients under anesthesia and under his care while they were in the operating room.” (St. Ex. 4 at 8)
- Nebraska Allegation 12: “Between approximately April 2000 to approximately February 2002, [Dr. Menon] failed to use filtered needles to withdraw medication from glass ampules.” (St. Ex. 4 at 8)

Response during this hearing: Dr. Menon indicated that, with glass ampules, he used a filtered needle to withdraw the medication. (Tr. I at 159)

- Nebraska Allegation 13: “Between approximately June 1, 2000 and approximately March 13, 2002, [Dr. Menon] wrote himself twenty six (26) prescriptions for Viagra.” (St. Ex. 4 at 8)

Response during this hearing: Dr. Menon disagreed that he wrote 26 separate Viagra prescriptions for himself. Instead, he testified that he

wrote prescriptions four or five times, each for three or four tablets. (Tr. I at 122)

- Nebraska Allegation 14: “On approximately September 10, 2003, [Dr. Menon] lied to a Department Investigator during an interview when he denied prescribing controlled substances for patients outside the hospital. A prescription audit obtained from F. Pharmacy showed three (3) prescriptions for Tylox (oxycodone with APAP 5/500), a controlled substance, had been written by [Dr. Menon] for patient J.B.” (St. Ex. 4 at 8)

Response during this hearing: Dr. Menon stated that, one time, he signed a prescription that was already filled out for a patient for whom he handled anesthesia and that he did not realize at that time what Tylox was. He explained that the prescription was filled out and handed to him for a signature. (Tr. I at 98-99, 123-124)

- Nebraska Allegation 15: “Between approximately October 1, 1994 and October 31, 1994, [Dr. Menon’s] Clinical Privileges were revoked by Stouder Hospital in Troy, Ohio, for quality of care concerns.” (St. Ex. 4 at 9)
- Nebraska Allegation 16: On or February 21, 2002, [Community Hospital in McCook, Nebraska] informed [Dr. Menon] that his contract was terminated due to [Dr. Menon’s] substandard care and treatment practices. (St. Ex. 4 at 9)
- Nebraska Allegation 17: [Dr. Menon] failed to report the above-described loss of privileges and termination to the [Nebraska Board] within the mandatory thirty day reporting time period. (St. Ex. 4 at 9)

26. Dr. Menon explained that he did not contest the allegations in Nebraska because he did not want to displease the Nebraska Board. Dr. Menon was worried that any disciplinary litigation in Nebraska could negatively impact his Federation Licensing Examination [FLEX] results. Dr. Menon believed that, because he took the FLEX at a testing site in Nebraska in 1981 or 1982, displeasing the Nebraska Board in the 2005 disciplinary matter could negatively affect his FLEX results. (Tr. I at 97, 100, 102, 113-115, 125, 145-146)

Post-2003 Board Order Compliance – Notification of Other States’ Actions

27. The 2003 Board Order required Dr. Menon to notify the Board “of any action taken against a certificate to practice held by Dr. Menon in any other state” and to provide “acceptable documentation verifying the other state boards’ actions.” (St. Ex. 2 at 6)

28. Ms. Bickers testified that Dr. Menon did not notify the Board of the actions taken by the Iowa Board in September 2004, the Arizona Board in January 2005, or the Nebraska Board in April 2005. Ms. Bickers explained that, to report another state's action in compliance with that requirement of the 2003 Board Order, Dr. Menon could have sent a letter or used the declaration of compliance form by expressly noting that another state had taken action. Ms. Bickers stated that, even if the other state action had been added to the National Practitioner Databank, Dr. Menon was still required to affirmatively notify the Board of the other states' actions and his failure to do so violated the 2003 Board Order. (Tr. I at 39-40, 60, 62-63)
29. Dr. Menon acknowledged that he did not notify the Board of the Iowa, Arizona or Nebraska Boards' actions. He explained that, because of the information-sharing that occurred among the state boards after his Oklahoma disciplinary decision, he thought the other states would notify Ohio through, for example, the National Practitioner Databank. Dr. Menon stated that, at that time, he did not understand that *he* had to report other states' actions to the Board. (Tr. I at 95, 101, 103, 128)

Letters of Support

30. Dr. Menon presented three letters from two doctors with whom he worked while in McCook, Nebraska. The State did not have the opportunity to examine either doctor. The first two letters were written by Dr. Eskildsen, a general surgeon with whom Dr. Menon worked extensively during that time period. Dr. Eskildsen noted that Dr. Menon handled the anesthesia needs for high-risk elderly patients, severe oxygen-dependent "COPD" patients, and critically ill patients. Dr. Eskildsen stated that Dr. Menon "demonstrated his knowledge and expertise in getting these sick patients safely through their operations." Also, Dr. Eskildsen noted that those patients for whom Dr. Menon handled the epidural anesthesia and post-operative pain control had excellent pain control results, with very few exceptions. Dr. Eskildsen further stated that he did not witness any breaches of sterile techniques, did not have any episodes in which he would question Dr. Menon's judgment, and did not feel that Dr. Menon endangered Dr. Eskildsen's patients. (Resp. Exs. E, F; Tr. I at 104, 150)
31. The third letter was written by Richard W. Slovek, M.D., an orthopedic surgeon who also worked with Dr. Menon. Dr. Slovek noted his opinion that Dr. Menon performed "competent anesthesia in a timely and professional manner." In addition, Dr. Slovek wrote:

I have respected [Dr. Menon's] vast knowledge of anesthesia. He appears to be well read in his field. I have enjoyed knowing him and would highly recommend him for anesthesiology services.

(Resp. Ex. G; Tr. I at 107, 150)

Summary of Actions Taken and Proceedings against Dr. Menon

32. The following chart summarizes the actions taken and proceedings against Dr. Menon since 1994.

Summary of Actions Taken and Proceedings against Dr. Menon since 1994

Date	Entity	Nature of Action	Basis for Action
10/94	Stouder Memorial Hospital in Troy, Ohio	Hospital appointment and privileges terminated.*	Quality of care concerns.*
11/98	Piqua Memorial Medical Center in Piqua, Ohio	Employment terminated.*	Quality of care concerns.*
9/02	Oklahoma Board	License reinstatement denied.*	Submission of false information on reinstatement application and loss of privileges at two Ohio hospitals.*
5/03	Ohio Board -- <i>Menon I</i>	One-year suspension, stayed; probation for at least three years, personal appearance at beginning and end of probation period, quarterly declarations, medical records course, practice plan with monitoring physician, required reporting of actions by any other state in which a certificate held.*	Oklahoma action.*
9/04	Iowa Board	Indefinite suspension, ethics course requirement, and CPEP evaluation.	Oklahoma action.
1/05	Arizona Board	Public reprimand.	Oklahoma and Ohio actions.
4/05	Nebraska Board	License surrendered for two years.	Failure to keep adequate records, minimum standards violations, self-prescribing, making a false statement to a Nebraska Board investigator, and failure to file a mandatory report.
8/05	Ohio Board -- <i>Menon II</i>	Pending as part of the current consolidated matters. (Ohio certificate permanently revoked 12/05. Decision appealed on service-related grounds. Ohio certificate reinstated 11/06, subject to the terms of the 2003 Ohio Board Order and pending evaluation of the 8/05 allegations on the merits.)	N/A
11/06	Ohio Board -- <i>Menon III</i>	Pending as part of the current consolidated matters.	N/A

FINDINGS OF FACT

1. On May 14, 2003, the Board issued an Order in the *Matter of Venu G. Menon, M.D.*, which suspended Dr. Menon's Ohio certificate to practice medicine and surgery for at least

*This information is provided for context/historical purposes only. These actions are *not* part of the allegations contained in the August 10, 2005, and the November 9, 2006, Notices of Opportunity for Hearing.

one year, stayed that suspension, and imposed probationary terms, conditions, and limitations for at least three years. The 2003 Board Order was based upon action taken by the Oklahoma Board in September 2002 denying Dr. Menon's request to reinstate his Oklahoma license. The Oklahoma disciplinary action was based upon Dr. Menon's submission of false information on his reinstatement application and his loss of privileges at two Ohio hospitals due to quality of care concerns.

Among the probationary terms, conditions, and limitations, this Board required Dr. Menon to: (a) provide quarterly declarations of compliance with the Order's probationary terms, conditions, and limitations; (b) ensure that his monitoring physician [MP] provided quarterly reports to the Board when due; and (c) notify the Board when any action is taken against his certificate to practice in any other state. Those probationary terms, conditions, and limitations became effective on May 13, 2003.

In December 2005, the Board revoked Dr. Menon's Ohio certificate. In November 2006, his Ohio certificate was reinstated, subject to the terms of the 2003 Board Order.

2. The Board did not receive declarations of compliance from Dr. Menon by February 1, August 1, and November 1, 2005, in compliance with the 2003 Board Order, specifically paragraph (A)(3). By his own admission, Dr. Menon did not take steps to ensure that those quarterly declarations were actually received by the Board and did not ask the Board whether those quarterly declarations were received by the Board in a timely manner. By his own admission, Dr. Menon did not document the dates by which his declarations of compliance were due so that he would execute and provide the declarations by the deadlines established in the 2003 Board Order. By his own admission, Dr. Menon did not keep copies of the executed forms. Dr. Menon also admitted that he did not know of the deadlines. The only evidence that those three declarations of compliance were provided when due was Dr. Menon's testimony that he executed the forms "every three months" and sent them to the Board. This evidence does not establish that Dr. Menon submitted declarations of compliance by February 1, August 1, and November 1, 2005, in compliance with the 2003 Board Order.

Additionally, the Board did not receive a declaration of compliance from Dr. Menon by May 1, 2005, in compliance with the 2003 Board Order, specifically paragraph (A)(3). Although, on June 6, 2005, the Board did receive a declaration of compliance from Dr. Menon, which was signed on May 30, 2005.

3. The Board did not receive MP reports from Dr. Jacob by February 1, May 1, August 1, and November 1, 2005, in compliance with the 2003 Board Order, specifically paragraph (A)(5). By his own admission, Dr. Menon did not take steps to ensure that those four quarterly MP reports were provided to the Board when due. By his own admission, Dr. Menon did not inquire of Dr. Jacob or the Board as to whether those MP reports were being submitted to the Board in a timely manner. Also, Dr. Menon did not seek to receive copies of those MP reports for his own files.

4. On September 15, 2004, the Iowa Board took action against Dr. Menon. It indefinitely suspended Dr. Menon's license in that state, required an ethics course, a competency evaluation, and completion of an educational program. This action was based upon the action taken by the Oklahoma Board in September 2002.
5. On January 4, 2005, the Arizona Board took action against Dr. Menon. It issued a letter of reprimand against Dr. Menon, based on the actions taken by the Oklahoma Board and this Board in *Menon I*.
6. On April 6, 2005, the Nebraska Board issued an order accepting a settlement agreement between Dr. Menon and the State of Nebraska, pursuant to which Dr. Menon agreed to surrender his Nebraska license for at least two years. This action was based upon allegations of: failure to keep adequate records, minimal standards violations, self-prescribing, making a false statement to a Nebraska Board investigator, and failure to file a mandatory report. Dr. Menon admitted those allegations in the settlement agreement.
7. Dr. Menon admitted that he did not notify the Board of the Iowa, Arizona or Nebraska Boards' actions identified in Findings of Fact 4-6, as required by the 2003 Board Order, specifically paragraph (A)(9).

CONCLUSIONS OF LAW

1. The conduct of Venu Gopal Menon, M.D., as set forth in Findings of Fact 2, 3, and 7, constitutes a "[v]iolation of the conditions of limitation placed by the board upon a certificate to practice," as that language is used in Section 4731.22(B)(15), Ohio Revised Code.
2. The April 2005 Nebraska Board action, as set forth in Finding of Fact 6, constitutes "[a]ny of the following actions taken by the agency responsible for regulating the practice of medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or the limited branches of medicine in another jurisdiction, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual's license to practice; acceptance of an individual's license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand," as that language is used in Section 4731.22(B)(22), Ohio Revised Code.

* * * * *

Respondent's counsel correctly notes that the Board has alleged violations of three components of the probationary terms, conditions, and limitations of the 2003 Board Order. Upon review of the evidence presented, Dr. Menon admitted that he violated the provisions requiring him to ensure that the MP reports were timely submitted and notify the Board of other state's actions.

With regard to the declarations of compliance required by the 2003 Board Order, the record demonstrates that Dr. Menon did not provide a declaration of compliance by the May 2005 due date and Dr. Menon did not present any evidence to demonstrate otherwise. The only evidence that Dr. Menon presented to establish that he submitted the missing declarations of compliance by their February 1, August 1, and November 1, 2005, due dates, was his statement that he signed the forms and mailed them to the Board. This testimony is not convincing for several reasons. First, Dr. Menon did little to ensure his compliance with the declaration requirements, including the fact that he did not bother to identify the deadlines. Second, of the six declarations that were received by the Board, only one declaration was signed and sent before its deadline. Most were overdue by 26 days or more. Third, Dr. Menon was not taking steps to comply with other probationary terms, conditions, and limitations and it is, therefore, unlikely that he timely submitted the three missing declarations.

Respondent's counsel contends that the allegations against Dr. Menon in these consolidated matters are not failures to meet minimal standards. However, that argument is not quite correct. One of the Board's allegations in these consolidated matters involves the action against Dr. Menon by the Nebraska Board. That board's April 2005 action was based, in part, upon admitted allegations involving minimal standard violations. Thus, apart from finding violations of the 2003 Board Order, the Hearing Examiner has found that Dr. Menon was disciplined by another state, based in part upon minimal standard violations.

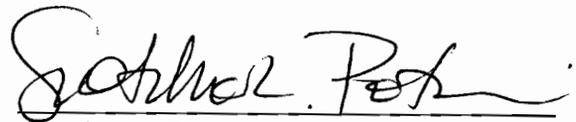
Dr. Menon requests that his Ohio certificate be suspended for one year and that he be given credit for the eight months in which his Ohio certificate was revoked in 2005-2006. The Hearing Examiner rejects that recommendation. As set forth in the final chart of this Report and Recommendation, Dr. Menon has an extensive disciplinary history. Five states in which Dr. Menon has held a medical license have taken action against him and those actions were based upon a variety of different circumstances. Although some of the actions are linked, this is not a situation in which Dr. Menon has been disciplined by various states solely for the same underlying events. In its 2003 Board Order, the Board reserved the right to impose *any* disciplinary action deemed appropriate if Dr. Menon violated the probationary terms, conditions, and limitations in any respect. Dr. Menon has violated the probationary terms, conditions, and limitations, and, in light of the history involved with Dr. Menon, the Board should permanently revoke his Ohio certificate. Dr. Menon has admitted to self-prescribing medication, signing a prescription for a medication with which he is not familiar, and prescribing medication for someone who was not his patient at the time. Dr. Menon has lost employment and/or hospital privileges from more than one hospital due to patient care concerns. Plus, he submitted false information to another state medical board and lied to another board's investigator. These events took place in several different locations and over a period of many years. Dr. Menon is not deserving of an Ohio certificate.

PROPOSED ORDER

It is hereby ORDERED that:

PERMANENT REVOCATION: The certificate of Venu Gopal Menon, M.D., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED.

This Order shall become effective immediately upon mailing notification of approval by the Board.

A handwritten signature in black ink, appearing to read "Gretchen L. Petrucci", written over a horizontal line.

Gretchen L. Petrucci
Hearing Examiner



State Medical Board of Ohio

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EXCERPT FROM THE DRAFT MINUTES OF JUNE 13, 2007

REPORTS AND RECOMMENDATIONS

Dr. Kumar announced that the Board would now consider the Reports and Recommendations appearing on its agenda. He asked whether each member of the Board had received, read, and considered the hearing records, the proposed findings, conclusions, and orders, and any objections filed in the matters of: Steven Franklin Greer, M.D.; Mohsen Karimi, M.D.; and Venu Gopal Menon, M.D. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Varyani	- aye
	Dr. Madia	- aye
	Mr. Browning	- aye
	Ms. Sloan	- aye
	Dr. Amato	- aye
	Dr. Robbins	- aye
	Dr. Kumar	- aye

Dr. Kumar asked whether each member of the Board understands that the disciplinary guidelines do not limit any sanction to be imposed, and that the range of sanctions available in each matter runs from dismissal to permanent revocation. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Varyani	- aye
	Dr. Madia	- aye
	Mr. Browning	- aye
	Ms. Sloan	- aye
	Dr. Amato	- aye
	Dr. Robbins	- aye
	Dr. Kumar	- aye

Dr. Kumar noted that, in accordance with the provision in Section 4731.22(F)(2), Revised Code, specifying that no member of the Board who supervises the investigation of a case shall participate in further adjudication of the case, the Secretary and Supervising Member must abstain from further participation in the adjudication of these matters. They may, however, participate in the matter of Dr. Karimi, as that case is not disciplinary in nature and concerns only the doctor's qualifications for licensure. In the matters before the Board today, Dr. Talmage served as Secretary and Mr. Albert served as Supervising Member.

The original Reports and Recommendations shall be maintained in the exhibits section of this Journal.

Dr. Talmage left the meeting at this time.

.....

VENU GOPAL MENON, M.D.

.....

DR. VARYANI MOVED TO APPROVE AND CONFIRM MS. PETRUCCI'S FINDINGS OF FACT, CONCLUSIONS, AND PROPOSED ORDER IN THE MATTER OF VENU GOPAL MENON, M.D. MS. SLOAN SECONDED THE MOTION.

.....

A vote was taken on Dr. Varyani's motion to approve and confirm:

ROLL CALL:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Varyani	- aye
	Dr. Madia	- aye
	Mr. Browning	- aye
	Ms. Sloan	- aye
	Dr. Amato	- aye
	Dr. Robbins	- aye

The motion carried.



State Medical Board of Ohio

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November 9, 2006

Venu Gopal Menon, M.D.
610 Boxwood Ct.
Troy, OH 45373

Dear Doctor Menon:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio [Board] intends to determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery, or to reprimand you or place you on probation for one or more of the following reasons:

- (1) On or about May 14, 2003, the Board entered an Order that adopted the Hearing Examiner's Report and Recommendation, suspended your certificate to practice medicine and surgery in the State of Ohio for one year, stayed said suspension, and placed probationary terms, conditions, and limitations on your certificate to practice medicine and surgery for a period of at least three years. A copy of the Board's May 14, 2003 Entry of Order [2003 Ohio Board Order] is attached hereto and fully incorporated herein.

By letter dated August 10, 2005, the Board issued a Notice of Opportunity for Hearing by which it proposed to determine whether or not to limit, revoke, permanently revoke, or suspend your certificate, refuse to issue or reinstate your certificate, or to reprimand you or place you on probation based on allegations that you had violated Sections 4731.22(B)(15) and (22), Ohio Revised Code [August 2005 Notice of Opportunity for Hearing]. On or about December 14, 2005, the Board issued a "Findings, Order and Journal Entry" permanently revoking your certificate to practice medicine and surgery in the State of Ohio, based upon your violation of the Board's 2003 Ohio Board Order, as well as the February 22, 2005 Agreed Settlement between you and the Nebraska Department of HHS Regulation and Licensure, whereby you voluntarily surrendered your medical license in the State of Nebraska for a minimum period of two years in lieu of disciplinary proceedings. After an appeal relating to the issue of service of the August 2005 Notice of Opportunity for Hearing, the Board, on or about October 10, 2006, vacated its order of December 14, 2005, and, on or about October 23, 2006, resent its August 2005 Notice of Opportunity for Hearing, which remains pending.

- (2) The 2003 Ohio Board Order remained in effect until on or about December 14, 2005. Further, upon the Board vacating its order of December 14, 2005, your

Mailed 11-9-06

certificate is again subject to the probationary terms, conditions, and limitations placed on your certificate by the 2003 Ohio Board Order.

- (a) Paragraph (A)(3) of the 2003 Ohio Board Order states that you “shall submit quarterly declarations under penalty of Board disciplinary action or criminal prosecution, stating whether there has been compliance with all the conditions of this Order.” Despite the requirements of Paragraph (A)(3), you failed to submit a quarterly declaration that was due in November of 2005.
- (b) Paragraph (A)(5) of the 2003 Ohio Board Order states that your “monitoring physician shall provide the Board with reports on the monitoring of [you] and [your] medical practice, and on the review of [your] patient charts” and that you “shall ensure that the reports are forwarded to the Board on a quarterly basis and are received in the Board’s offices no later than the due date for [your] quarterly declaration.” Despite the requirements of Paragraph (A)(5), you failed to ensure that your monitoring physician forwarded to the Board the quarterly report that was due in November of 2005.
- (c) Paragraph (A)(9) of the 2003 Ohio Board Order states that you “shall notify the Board of any action taken against a certificate to practice held by [you] in any other state.” Despite the requirements of Paragraph (A)(9), you failed to notify the Board that, on or about January 4, 2005, the Arizona Medical Board issued “Findings of Fact, Conclusions of Law and Order” in the Matter of Venu G. Menon, M.D. [Arizona Board Order]. Pursuant to the Arizona Board Order, you were issued a Letter of Reprimand for actions taken by the Medical Boards in Ohio and Oklahoma. A copy of the Arizona Board Order is attached hereto and incorporated herein.

Your acts, conduct, and/or omissions as alleged in paragraph (2) above, individually and/or collectively, constitute a “[v]iolation of the conditions of limitation placed by the board upon a certificate to practice,” as that clause is used in Section 4731.22(B)(15), Ohio Revised Code.

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty days of the time of mailing of this notice.

You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

Venu Gopal Menon, M.D.

Page 3

In the event that there is no request for such hearing received within thirty days of the time of mailing of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery or to reprimand you or place you on probation.

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, provides that "[w]hen the board refuses to grant a certificate to an applicant, revokes an individual's certificate to practice, refuses to register an applicant, or refuses to reinstate an individual's certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a certificate to practice and the board shall not accept an application for reinstatement of the certificate or for issuance of a new certificate."

Copies of the applicable sections are enclosed for your information.

Very truly yours,



Lance A. Talmage, M.D.
Secretary

LAT/KSP/fib
Enclosures

CERTIFIED MAIL # 7004 2510 0006 9802 9490
RETURN RECEIPT REQUESTED
RESTRICTED DELIVERY

Elizabeth Y. Collis, Esq.
1650 Lake Shore Drive, Suite 225
Columbus, OH 43204

CERTIFIED MAIL # 7004 2510 0006 9802 9483
RETURN RECEIPT REQUESTED



Arizona Medical Board

9545 East Doubletree Ranch Road • Scottsdale, Arizona 85258-5514
Telephone: 480-551-2700 • Toll Free: 877-255-2212 • Fax: 480-551-2700
Website: www.azmd.gov • Email: questions@azmd.gov

STATE MEDICAL BOARD
OF OHIO

2005 AUG 10 A 10:17

Governor

Janet Napolitano

Members of the Board

Tim B. Hunter, M.D.
Chair
Physician Member

William R. Martin, III, M.D.
Vice-Chair
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Physician Member

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Dona M. Pardo, Ph.D., R.N.
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Executive Staff

Timothy C. Miller, J.D.
Executive Director

Amanda J. Diehl, M.P.A.
Deputy Executive Director

Bernadette E. Phelan, Ph.D.
Assistant Director

Roger Downey
Public Information Officer

I, Christi Banyas, of the Arizona Medical Board, hereby certify that I am the official custodian of the records of the agency; and that the attached documents are true and complete copies of the actions requested regarding:

Physician Name: Venu G. Menon, MD

License Number: 12360

Attached are the following document(s):

Document Name:

Profile

Findings of Fact, Conclusion of Law and Order (Letter of Reprimand) Dated January 4 2005

Document (# of pages) 6

DATED this 8th day of August, 2005

ARIZONA MEDICAL BOARD

[SEAL]

Christi Banyas
Custodian of Records



Arizona Medical Board Physician Profile

Printed: 8/8/2005 10:29:39 AM from <http://www.azmdboard.org>

General Information

Venu G. Menon MD
1010 Woodman Dr Ste 100
Dayton Ohio 45432-1429
Phone: 937-252-2000

License Number: 12360
License Status: Active
License Date: 10/17/1980
License Renewed: 10/20/2004
Renew By: 09/2006
License Expires: 01/2007

Education and Training (a)

Medical School: ALL INDIA INST OF MED SCI, ANSARI NAGAR
NEW DELHI, INDIA
Graduation Date: 2/4/1963

Residency: 7/1/1975 - 6/30/1976 (Anesthesiology)
BRONX MUNICIPAL HOSPITAL CENTER
BRONX, NEW YORK

Residency: 7/1/1976 - 6/30/1977 (Anesthesiology)
UNIVERSITY OF LOUISVILLE HOSPITAL
LOUISVILLE, KENTUCKY

(b) Area of Interest: Pain Management (Anesthesiology) (ABMS Board Certified)
(b) Area of Interest: Anesthesiology

Board Investigations and Actions

BOARD ACTIONS: 1
* OPEN INVESTIGATIONS: 0

NON DISCIPLINARY ACTIONS: 0

* Open investigations represent unproven allegations - Upon investigation many complaints are found to be without merit and dismissed.

BOARD ACTIONS (d)

2/9/2005 : Letter of Reprimand for action taken by other state regulatory boards for unprof. cond. of knowingly making a false or misleading statement on a form reqd by the Board.

Malpractice/Criminal Information

CRIMINAL CONVICTIONS /
"NO CONTEST" PLEAS: 0

(e) MALPRACTICE CASES
RESULTING IN PAYMENT: 0

The Arizona Medical Board presents this information as a service to the public. The Board relies upon information provided by licensees to be true and correct, as required by statute. It is an act of unprofessional conduct for a licensee to provide erroneous information to the Board. The Board makes no warranty or guarantee concerning the accuracy or reliability of the content of this website or the content of any other website to which it may link. Assessing accuracy and reliability of the information obtained from this website is solely the responsibility of the user. The Board is not liable for errors or for any damages resulting from the use of the information contained herein.

(a) Information up to the date of initial licensure is verified by the Board. Information provided by the physician after this date is not verified by the Board.

(b) The Board does not verify current specialties. For more information please see the American Board of Medical Specialties website at: <http://www.abms.org> to determine if the physician has earned a specialty certification from this private agency.

(d) Advisory Letters and Physician Responses to the Advisory Letters are only available on-line for a 5 year period from date of issuance by the Board.

(e) The settlement of a medical malpractice action may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the doctor. A payment in settlement of a medical malpractice action does not create a presumption that medical malpractice occurred.

(f) Prior to 1999, "Advisory Letters" were known as "Letters of Concern"

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BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

VENU G. MENON, M.D.

Holder of License No. **12360**
For the Practice of Allopathic Medicine
In the State of Arizona.

Board Case No. MD-03-0684A

**FINDINGS OF FACT,
CONCLUSIONS OF LAW
AND ORDER**

(Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on October 14, 2004. Venu G. Menon, M.D., ("Respondent") appeared before the Board without legal counsel for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following findings of fact, conclusions of law and order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.
2. Respondent is the holder of License No. 12360 for the practice of allopathic medicine in the State of Arizona.
3. The Board initiated case number MD-03-0684A after receiving notification that on May 14, 2003 the State Medical Board of Ohio suspended Respondent's certificate to practice medicine and surgery for one year. The suspension was stayed and Respondent was placed on three years probation. Ohio's action was based on the Oklahoma State Board of Medical Licensure and Supervision denying reinstatement of Respondent's medical license because of his loss of privileges at two hospitals in Ohio

1 based on quality of care issues and his submittal of false information on his Oklahoma
2 reinstatement application.

3 4. Respondent was asked why he answered the question on the Oklahoma
4 application relating to hospital privileges being denied, removed or suspended in the
5 negative when he had lost privileges at a hospital in Ohio because of his recordkeeping
6 and unavailability for service. Respondent stated that he did not consider the Ohio
7 hospital's action a termination of his privileges. Respondent maintained he did not
8 consider the action a termination even after the Board noted that the letter he received
9 from the hospital was a letter of termination.

10 5. Respondent was asked about the termination of privileges by a second
11 Ohio hospital for quality of care concerns. Respondent testified that the quality of care
12 issue was really nothing at all and he was terminated for political reasons. Respondent
13 was asked how he could again maintain his privileges were not terminated for quality of
14 care issues when the letter from this hospital also indicated that his privileges were
15 removed due to quality of care concerns. Respondent stated that he answered the
16 question honestly.

17 6. Respondent was asked about his answering "no" to the question whether
18 he had ever been named as a defendant in a civil suit, including malpractice, when on
19 the same application he admitted to having paid a malpractice claim. Respondent
20 stated that since the claim was paid outside of a court action he marked "no" to the
21 question about the suit, but "yes" to the question about a malpractice claim.

22 6. Respondent's answers to the questions on his Oklahoma application are
23 knowingly false or misleading.

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RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board within thirty (30) days after service of this Order and must set forth legally sufficient reasons for granting a rehearing or review. A.R.S. § 41-1092.09, A.A.C. R4-16-102, it. Service of this order is effective five (5) days after date of mailing. If a motion for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 4 day of JANUARY, 2005.



THE ARIZONA MEDICAL BOARD

By *Timothy C. Miller*
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 5 day of JANUARY, 2005 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing
mailed by U.S. Certified Mail this
5 day of JANUARY, 2005, to:

Venu G. Menon, M.D.
Address of Record

Venu G. Menon



State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.med.ohio.gov

August 10, 2005

Venu Gopal Menon, M.D.
610 Boxwood Ct.
Troy, OH 45373

Dear Doctor Menon:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio [Board] intends to determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery, or to reprimand you or place you on probation for one or more of the following reasons:

- (1) By letter dated December 11, 2002, the Board notified you that it proposed to determine whether or not to limit, revoke, permanently revoke, or suspend your certificate, refuse to issue or reinstate your certificate, or to reprimand you or place you on probation based on allegations that the Oklahoma State Board of Medical Licensure and Supervision had filed an "Order Denying Reinstatement of [Dr. Menon's] Medical License" [Oklahoma Board Order]. The Board alleged that the Oklahoma Board Order constituted "[a]ny of the following actions taken by the agency responsible for regulating the practice of medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or the limited branches of medicine in another jurisdiction, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual's license to practice; acceptance of an individual's license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand," as that clause is used in Section 4731.22(B)(22), Ohio Revised Code.

On or about January 10, 2003, you submitted a written hearing request, and the matter came to hearing in front of an Attorney Hearing Examiner for the Board on March 18, 2003. On or about April 14, 2003, the Attorney Hearing Examiner issued a Report and Recommendation In The Matter of Venu G. Menon, M.D. Said Report and Recommendation included the following finding of fact:

On September 26, 2002, the Oklahoma State Board of Medical Licensure and Supervision filed an Order Denying Reinstatement of Medical License concerning Venu G. Menon, M.D. The Oklahoma Board found that Dr. Menon had submitted false information on his reinstatement application and that he had

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previously lost privileges at two hospitals in Ohio based upon quality of care issues.

- (2) On or about May 14, 2003, the Board entered an Order that adopted the Hearing Examiner's Report and Recommendation, suspended your certificate to practice medicine and surgery in the State of Ohio for one year, stayed said suspension, and placed probationary terms, conditions, and limitations on your certificate to practice medicine and surgery for a period of at least three years. A copy of the Board's May 14, 2003, Entry of Order [Ohio Board Order] is attached hereto and fully incorporated herein.
 - (a) Paragraph (A)(3) of the Ohio Board Order states that you "shall submit quarterly declarations under penalty of Board disciplinary action or criminal prosecution, stating whether there has been compliance with all the conditions of this Order." Despite the requirements of Paragraph (A)(3), you failed to submit quarterly declarations that were due in February of 2005 and August of 2005. Further, although you submitted a quarterly declaration in May of 2005, the declaration, which was due on May 1, 2005, was not completed by you until May 30, 2005, and not received by the Board until June of 2005.
 - (b) Paragraph (A)(5) of the Ohio Board Order states that your "monitoring physician shall provide the Board with reports on the monitoring of [you] and [your] medical practice, and on the review of [your] patient charts" and that you "shall ensure that the reports are forwarded to the Board on a quarterly basis and are received in the Board's offices no later than the due date for [your] quarterly declaration." Despite the requirements of Paragraph (A)(5), you failed to ensure that your monitoring physician forwarded to the Board the quarterly reports that were due in February of 2005, May of 2005, and August of 2005.
 - (c) Paragraph (A)(9) of the Ohio Board Order states that you "shall notify the Board of any action taken against a certificate to practice held by [you] in any other state." Despite the requirements of Paragraph (A)(9), you failed to notify the Board of the following actions taken against your certificates to practice in other states:
 - (i) On or about September 15, 2004, the Board of Medical Examiners of the State of Iowa issued a Final Order In The Matter Of The Statement Of Charges Against Venu G. Menon, M.D., Respondent [Iowa Board Order]. Pursuant to the Iowa Board Order, your license to practice medicine and surgery in the State of Iowa was indefinitely suspended with specific requirements for reinstatement. A copy of the Iowa Board Order is attached hereto and incorporated herein.

- (ii) On or about April 6, 2005, the Department of Health and Human Services Regulation and Licensure for the State of Nebraska [Nebraska Department of HHS Regulation and Licensure], issued an order adopting an Agreed Settlement between you and the Nebraska Department of HHS Regulation and Licensure, whereby you voluntarily surrendered your medical license in the State of Nebraska for a minimum period of two years in lieu of disciplinary proceedings. A copy of the Nebraska Department of HHS Regulation and Licensure Order on Agreed Settlement and Petition for Disciplinary Action are attached hereto and incorporated herein.
- (3) On or about February 22, 2005, you signed an Agreed Settlement with the Nebraska Department of HHS Regulation and Licensure, whereby you voluntarily surrendered your medical license in the State of Nebraska for a minimum period of two years in lieu of disciplinary proceedings. By signing said Agreed Settlement, you admitted to the allegations contained in the Nebraska Petition for Disciplinary Action. Further, you consented to having the Director of the Nebraska Department of HHS Regulation and Licensure issue a final disciplinary order, in which the allegations in the Nebraska Petition for Disciplinary Action were determined to be true. On or about April 6, 2005, the Director of the Nebraska Department of HHS Regulation and Licensure adopted the Agreed Settlement and the admitted factual allegations contained in the Petition for Disciplinary Action. The allegations of fact to which you admitted are fully set forth in the attached Nebraska Department of HHS Regulation and Licensure Order on Agreed Settlement and Petition for Disciplinary Action. Among the admitted factual allegations are the following:
 - (a) Between approximately April 2000 to approximately February 2002, [you were] engaged in a contractual relationship with (CH) of McCook, [Nebraska], to provide professional anesthesia services.
 - (b) On or about July 6, 2001, between approximately 12:15 p.m. and approximately 2:00 p.m., [you] attempted to intubate patient G.R. for administration of general anesthesia eight (8) to twelve (12) times without success. During the intubation attempts, [you] ordered Nurse S.B. to draw-up and administer numerous doses of succinylcholine, a paralytic agent. During the failed attempts, patient G.R.'s oxygen saturation levels dropped to between 30% and 40%. [You] failed to chart the orders to Nurse S.B. for the administration of succinylcholine, and failed to chart all oxygen levels.
 - (c) Between approximately April 2000 to approximately February 2002, [you] prescribed antibiotic medication for a patient without documenting in the patient's chart the medications prescribed or the purpose for which they were prescribed. [You] admitted in interviews conducted on September

10, 2003 and September 15, 2003, that [you] provided [your] girlfriend antibiotics by using hospital prescription pads and that [you] did not keep any records of the medical care [you] provided to [your] girlfriend.

- (d) Between approximately April 2000 to approximately August 2001, [you] provided anesthesia services on numerous occasions for cataract procedures. In interviews ... conducted on September 10, 2002 and September 15, 2003, [you] admitted to re-using the same syringe on four (4) to five (5) patients each day in a three (3) to four (4) day time period. [You admitted you] continued the practice of reusing syringes on different patients until [you were] told by Nurse B. to stop.
- (e) Between approximately April 2000 to approximately February 2002, [you] failed to label each syringe [you] used to administer different medications during any given procedure. [You] admitted in interviews conducted on September 10, 2002 and September 15, 2003, that [you] regularly did not label syringes [you] used in each surgical case.
- (f) Between approximately April 2000 to approximately February 2002, [you were] observed by OR staff members, on more than one occasion, leaving a patient under [your] care, while the patient was under anesthesia, to wit:
 - (i) On or about May 30, 2001, a surgical procedure had to be stopped when a patient started moving around. At the time, [you were] in the hallway outside the operating room talking with a student. [You] had to be asked to return to the operating room to administer more sedation so the surgical procedure could be completed.
 - (ii) On other occasions, after administering anesthesia, [you] left [your] patients in the operating room to drink coffee outside the operating room.
- (g) On approximately September 10, 2003 and approximately September 15, 2003, during interviews with a Department Investigator, [you] admitted to being approximately 20 feet away from patients under anesthesia and under [your] care while they were in the operating room.
- (h) Between approximately April 2000 to approximately February 2002, [you] failed to use filtered needles to withdraw medication from glass ampules.
- (i) Between approximately June 1, 2000 and approximately March 13, 2002, [you] wrote [yourself] twenty six (26) prescriptions for Viagra.

- (j) On approximately September 10, 2003, [you] lied to a Department Investigator during an interview when [you] denied prescribing controlled substances for patients outside the hospital. A prescription audit obtained from F. Pharmacy showed three (3) prescriptions of Tylox (oxycodone with APAP 5/500), a controlled substance, had been written by [you] for patient J.B.

- (k) On or about February 21, 2002, CH informed [you] that [your] contract was terminated due to [your] substandard care and treatment practices.

Your acts, conduct, and/or omissions as alleged in paragraph (2) above, individually and/or collectively, constitute a “[v]iolation of the conditions of limitation placed by the board upon a certificate to practice,” as that clause is used in Section 4731.22(B)(15), Ohio Revised Code.

The Nebraska Department of Health and Human Services Regulation and Licensure Order on Agreed Settlement as alleged in paragraph (3) above constitutes “[a]ny of the following actions taken by the agency responsible for regulating the practice of medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or the limited branches of medicine in another jurisdiction, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual's license to practice; acceptance of an individual's license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand,” as that clause is used in Section 4731.22(B)(22), Ohio Revised Code.

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty days of the time of mailing of this notice.

You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

In the event that there is no request for such hearing received within thirty days of the time of mailing of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery or to reprimand you or place you on probation.

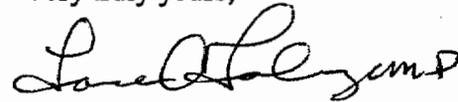
Venu Gopal Menon, M.D.

Page 6

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, provides that "[w]hen the board refuses to grant a certificate to an applicant, revokes an individual's certificate to practice, refuses to register an applicant, or refuses to reinstate an individual's certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a certificate to practice and the board shall not accept an application for reinstatement of the certificate or for issuance of a new certificate."

Copies of the applicable sections are enclosed for your information.

Very truly yours,



Lance A. Talmage, M.D.
Secretary

LAT/blt
Enclosures

CERTIFIED MAIL # 7003 0500 0002 4340 7452
RETURN RECEIPT REQUESTED

Elizabeth Y. Collis, Esq.
1650 Lake Shore Drive, Suite 180
Columbus, OH 43204

CERTIFIED MAIL # 7003 0500 0002 4340 7445
RETURN RECEIPT REQUESTED

REMAILED ON 10/23/2006 PER COURT ORDER TO:

Venu Gopal Menon, M.D.
610 Boxwood Court
Troy, OH 45373

CERTIFIED MAIL – RESTRICTED DELIVERY
RETURN RECEIPT REQUESTED
#7004 2510 0006 9801 5073

Elizabeth Y. Collis, Esq.
1650 Lake Shore Drive, Suite 180
Columbus, OH 43204

CERTIFIED MAIL - #7004 2510 0006 9801 5080
RETURN RECEIPT REQUESTED

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF IOWA

IN THE MATTER OF THE STATEMENT OF CHARGES AGAINST

VENU G. MENON, M.D., RESPONDENT

FILE No. 02-02-780

FINAL ORDER

BE IT REMEMBERED:

DATE: September 15, 2004.

1. Respondent was issued license number 23671 to practice medicine and surgery in Iowa on July 1, 1983.
2. Respondent's Iowa medical license is active and will next expire on September 1, 2005.
3. The Board has jurisdiction in this matter pursuant to Iowa Code Chapters 147, 148 and 272C.
4. The Board filed a Statement of Charges against Respondent's Iowa medical license on May 29, 2003. The Board charged Respondent with being disciplined by the medical licensing authority of another state in violation of the laws and rules governing the practice of medicine in Iowa.

5. A contested case hearing was held on the Statement of Charges before a three member panel of the Board on July 6, 2004.

6. A Proposed Decision and Order of the Panel (Proposed Decision) was issued by the Board on August 9, 2004.

7. A copy of the Proposed Decision was delivered to counsel for the State of Iowa, Heather Adams, Assistant Attorney General, on August 10, 2004.

8. A copy of the Proposed Decision was delivered to the Respondent via certified mail on August 13, 2004.

9. No appeal of the Proposed Decision was filed pursuant to Iowa Code Chapter 17A and 653 IAC 12.50.

THEREFORE IT IS HEREBY ORDERED that the Proposed Decision in this matter, a copy of which is attached as Exhibit A, is a **FINAL DECISION** of the Board and the Decision and Order outlined therein is a **FINAL ORDER OF THE BOARD**.



Bruce L. Hughes, M.D., Chairperson
Iowa Board of Medical Examiners
400 SW 8th Street, Suite C
Des Moines, IA 50309-4686

September 15, 2004

Date

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF IOWA

IN THE MATTER OF THE)	DIA NO. 03DPHMB010
STATEMENT OF CHARGES AGAINST:)	CASE NOS. 02-2002-0780
)	
)	
VENU G. MENON, M.D.)	PROPOSED DECISION AND
)	ORDER OF THE PANEL
Respondent)	
)	

On May 29, 2003 the Iowa Board of Medical Examiners (Board) filed a Statement of Charges against Venu G. Menon, M.D. (Respondent) alleging that the Respondent's license to practice medicine and surgery had been disciplined by the medical licensing authority of another state. The Complaint further alleged that the Iowa Board was authorized to take disciplinary action against the Respondent pursuant to Iowa Code section 148.6(2)(d) (2003).

An original Notice of Hearing was issued setting the hearing for July 9, 2003. The hearing was continued three times, twice at the Respondent's request. The Respondent's third request for continuance, filed on May 29, 2004, was denied. The hearing was held on July 6, 2004 at 8:40 a.m. The Respondent did not appear for the hearing and was not represented by counsel. The hearing was held before a panel of the Board: Bruce Hughes, M.D., Chairperson; Susan Johnson, M.D.; and Sally Schroeder, public member. Heather Adams, Assistant Attorney General, represented the state. The hearing was open to the public, pursuant to Iowa Code section 272C.6(1), and was recorded by a certified court reporter. Margaret LaMarche, Administrative Law Judge, assisted the panel in conducting the hearing and was instructed to prepare this proposed decision, in accordance with the panel's deliberations.

THE RECORD

The record includes the Statement of Charges, the Notice of Hearing, Orders Rescheduling and Continuing Hearing, Proof of Service, Request for Continuance, filed 5/29/04; Resistance; Order Denying Continuance; Motion To Amend Statement of Charges, filed 6/11/04; the testimony of the witness, and State Exhibits 1-9 (See Exhibit Index).

FINDINGS OF FACT

1. The Respondent was issued license number 23671 to practice medicine and surgery in the State of Iowa on July 1, 1983, as recorded in the permanent records in the office of the Board. The Respondent's license was renewed in 2001. (Testimony of Doug Brown; State Exhibits 2, 8)

2. On October 26, 2002, the Oklahoma State Board of Medical Licensure and Supervision denied Respondent's request for reinstatement of his Oklahoma medical license. In its Order Denying Reinstatement, the Oklahoma Board found that the Respondent had previously lost privileges at two Ohio hospitals due to quality of care concerns. The Oklahoma Board further found that the Respondent submitted false information on his reinstatement application. The Board concluded that the Respondent failed to sustain his burden of proof that he met all of the requirements for reinstatement, including but not limited to good moral character, ability to practice medicine and surgery with reasonable skill and safety, and that he is physically, mentally, professionally, and morally capable of practicing medicine and surgery in a manner reasonably acceptable to the Board.

a. In response to question J on the reinstatement application, the Respondent falsely answered "no" to the question "Have you ever been denied or had removed or suspended hospital staff privileges?" When the Oklahoma Board asked the Respondent why he gave an obviously wrong answer, he replied "I don't know why I marked there. I have no idea at all." (State Exhibit 6, p. 29)

b. In response to question L on the reinstatement application, the Respondent falsely answered "no" to the question "Have you ever been the subject of disciplinary action by a hospital, clinic, residency program, or professional school?" When asked about this response, the Respondent told the Oklahoma Board "I didn't know losing privileges is disciplinary action. I didn't know about that." (State Exhibit 6, p. 29)

c. In response to question M on the reinstatement application, the Respondent falsely answered "no" to the

question "Have you ever been named as a defendant in a civil suit (including malpractice?)"

d. The Respondent signed the reinstatement application, certifying that all statements made therein were true.

(Testimony of Doug Brown; State Exhibits 2-6)

3. The National Practitioner Data Bank has a Medical Malpractice Payment Report dated 8/3/93, indicating that a \$9,000 medical malpractice payment was made on behalf of the Respondent in settlement of a claim. This claim should have prompted the Respondent to answer "yes" to question "M" on the Oklahoma reinstatement application.

The National Practitioner Data Bank also has several adverse action reports concerning the Respondent's hospital privileges in Ohio, which should have prompted him to answer "yes" to questions "J" and "L" on the Ohio reinstatement application.

a. On 10/26/94, the Respondent was denied reappointment to the medical staff at Stouder Memorial Hospital because of quality of care concerns regarding the manner in which he completed medical records and longstanding and continuing concerns regarding his lack of availability during epidural anesthesia and on-call coverage. On 3/31/99, the Respondent filed a reply to this adverse action report denying that the report was truthful or accurate.

b. On 6/25/97, the Respondent was indefinitely required to use a scribe for all pre-operative and intra-operative reports at Piqua Memorial Medical Center. A subsequent entry on 10/8/97 reflects that the scribe requirement was lifted on 9/24/97. On 3/31/99, the Respondent filed a reply to this adverse action report stating that he was only required to have a scribe for fifty cases and never lost his privileges. The Respondent asserted that he was singled out when other physicians' had worse handwriting than his.

c. On 11/24/98, the Respondent's appointment and clinical privileges were terminated at Upper Valley Medical Center in Troy, Ohio for quality of care concerns. On 3/31/99, the Respondent filed a reply to this adverse action report denying that the report was truthful or accurate and further

stating that he had a lawsuit against the hospital that was scheduled to go to trial in January 2000.

d. On 5/16/03, the Ohio Medical Board suspended the Respondent's medical license for one year, but stayed the suspension subject to probationary terms and conditions for at least three years. This disciplinary action was based on the Oklahoma Board's action finding that the Respondent had submitted false information on his application for reinstatement.

(Testimony of Doug Brown; State Exhibit 9)

4. The Statement of Charges and original Notice of Hearing were served on the Respondent by restricted certified mail, return receipt requested, on June 7, 2003. The latest Order for Hearing was served on the Respondent by certified mail on May 21, 2004. On May 29, 2004, the Respondent wrote to the Board acknowledging receipt of the notice and requesting a continuance of the hearing. The continuance request was denied in an Order dated June 15, 2004. The Respondent did not appear for the hearing and did not ask to appear by telephone. (Order For Hearing; Proof of Service; Respondent Letter dated 5/29/04; Order Denying Continuance)

CONCLUSIONS OF LAW

I. Failure To Appear

653 IAC 12.12(1) provides that delivery of the notice of hearing together with a statement of charges constitutes the commencement of a contested case proceeding. Delivery may be executed by personal service as provided in the Iowa Rules of Civil Procedure, by restricted certified mail, return receipt requested, or by publication, as provided in the Iowa Rules of Civil Procedure.

653 IAC 12.28 provides that if a respondent, upon whom a proper notice of hearing has been served, fails to appear or participate in a contested case hearing, the presiding officer may, if no adjournment is granted, proceed with the hearing and render a decision in the absence of the party

The Respondent was properly served with the original notice of hearing and statement of charges by restricted certified mail on

June 7, 2003. He was subsequently served by certified mail with the Hearing Order rescheduling the hearing for July 6, 2004 and acknowledged receipt of the notice. The Respondent has been properly served but failed to appear for the hearing. The panel was authorized to proceed in his absence.

II. Motion To Amend Statement of Charges

On June 11, 2004, the state of Iowa filed a Motion To Amend Statement of Charges, seeking to add two additional legal counts: professional incompetency, in violation of Iowa Code section 147.55(2)(2003) and 653 IAC 12.4(2) [Count II]; and knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of medicine, in violation of Iowa Code section 147.55(3)(2003) and 653 IAC 12.4(3)(a)[Count III]. The motion was sent to the Respondent by first-class mail, but he has not filed a response. The panel denied the state's Motion to Amend the Statement of Charges because of the relatively short notice given to the Respondent. This matter had been pending for more than a year, and the Motion to Amend was not based on any new information.

III. Disciplinary Action In Another State

Iowa Code section 148.6(2)(d)(2003) provides in relevant part:

2. Pursuant to this section, the board of medical examiners may discipline a licensee who is guilty of any of the following acts or offenses:

...

d. Having the license to practice medicine and surgery, osteopathic medicine and surgery, or osteopathy revoked or suspended, or having other disciplinary action taken by a licensing authority of another state, territory, or country. A certified copy of the record or order of suspension, revocation, or disciplinary action is prima facie evidence.

The preponderance of the evidence established that on September 26, 2002, the Oklahoma State Board of Medical Licensure and Supervision took disciplinary action against the Respondent when it denied his request for reinstatement of his medical license. The Oklahoma Board's action was based on its affirmative findings that the Respondent: 1) lost privileges at two Ohio hospitals

based upon quality of care concerns; and 2) submitted false information on his reinstatement application. The Respondent never notified the Iowa Board of the disciplinary action in Oklahoma. On May 16, 2003 the Ohio State Medical Board also took disciplinary action against the Respondent based on the Oklahoma disciplinary action. The Respondent has violated Iowa Code section 148.6(2)(d)(2003) by having disciplinary action taken against him by the licensing authority of another state.

Because of the factual basis for the Oklahoma Board's action, this violation raises serious concerns about the Respondent's ability to ethically and competently practice medicine and surgery in the state of Iowa, consistent with the public health and welfare. The panel has determined that the Respondent must be required to satisfactorily address and resolve these concerns before he is permitted to practice in this state.

ORDER

IT IS THEREFORE ORDERED that the license to practice medicine and surgery in the state of Iowa, issued to Venu G. Menon, M.D., license number 23671, is hereby **INDEFINITELY SUSPENDED**.

IT IS FURTHER ORDERED that prior to seeking reinstatement of his Iowa medical license the Respondent shall successfully complete the following requirements:

A. ETHICS: Respondent shall successfully complete the Professional/Problem Based Ethics (PROBE) program sponsored by the Ethics Group, LLC, of Summit, New Jersey. Respondent shall be responsible for all costs associated with this program and shall ensure that the program sends a final report to the Board.

B. COMPETENCY EVALUATION: Respondent shall successfully complete a competency evaluation at the Center for Personalized Education for Physicians (CPEP) in Denver, Colorado. Respondent shall contact the Board to schedule the evaluation. Upon completion of the evaluation, a written report shall be provided to the Board by the evaluation program that identifies any area of deficiency in Respondent's medical practice. If areas of deficiency are identified and an educational program is recommended, Respondent shall successfully complete the educational

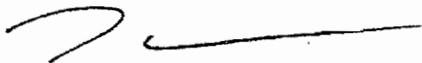
program. Respondent shall fully comply with all recommendations made by the evaluation program and the Board, including but not limited to any program of remediation. Respondent is solely responsible for all costs associated with the evaluation.

The Respondent may file an **Application for Reinstatement** of his license following his successful completion of these requirements.

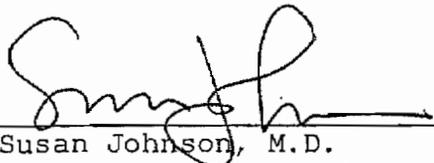
IT IS FURTHER ORDERED, in accordance with 653 IAC 12.43, that the Respondent shall pay a disciplinary hearing fee of \$75.00. In addition, the Respondent shall pay any costs certified by the executive director and reimbursable pursuant to subrule 12.43(3). All fees and costs shall be paid in the form of a check or money order payable to the state of Iowa and delivered to the department of public health, within thirty days of the issuance of a final decision.

Dated this 9th day of August, 2004.

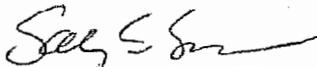
THE PANEL:



Bruce Hughes, M.D., Chairperson
Iowa Board of Medical Examiners



Susan Johnson, M.D.



Sally Schroeder, Public Member

cc: Heather Adams, Assistant Attorney General

In accordance with 653 IAC 12.28(3), this decision becomes final agency action, unless, within 15 days after the date of

notification or mailing of this decision, a motion to vacate is filed and served on all parties or an appeal of the decision on the merits is timely initiated within the time provided by 12.32(2). A motion to vacate shall state all facts relied upon by the moving party which establish that good cause existed for that party's failure to appear or participate at the contested case proceeding. Each fact so stated must be substantiated by at least one sworn affidavit or a person with personal knowledge of each such fact attached to the motion.

THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
REGULATION AND LICENSURE
STATE OF NEBRASKA

CREDENTIALING DIVISION

STATE OF NEBRASKA ex rel.,
JON BRUNING, Attorney General,

Plaintiff,

v.

venu G. MENON, M.D.,

Defendant.

APR 12 2005

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69 - 050354

ORDER
ON AGREED SETTLEMENT

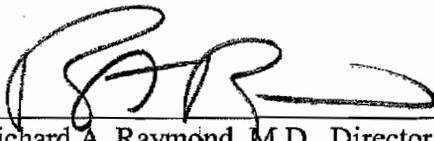
A PROPOSED AGREED SETTLEMENT, was filed with the Department on March 25, 2005.

ORDER

1. The Agreed Settlement is adopted, attached hereto and incorporated by reference.
2. The facts as set out in the petition are taken as true and adopted herein.
3. The parties shall comply with all of the terms of the Agreed Settlement.

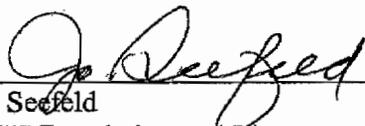
DATED this 6th day of April, 2005.




Richard A. Raymond, M.D., Director
Health and Human Services Department
Regulation and Licensure

CERTIFICATE OF SERVICE

COMES NOW the undersigned and certifies that on the 8 day of April, 2005, a copy of the foregoing ORDER ON AGREED SETTLEMENT was sent by certified United States mail, postage prepaid, return receipt requested to Venu G. Menon, M.D., 610 Boxwood Court, Troy, Ohio 45373 and by interagency mail to Bradley S. Shaff, Assistant Attorney General, 2115 State Capitol, Lincoln, Nebraska.


Jo Seefeld
HHS Regulation and Licensure
P.O. Box 95007
Lincoln, NE 68509-5007
(402) 471-0384

APR 12 2005

THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
REGULATION AND LICENSURE
STATE OF NEBRASKA

FILED

MAR 25 2005

**HHS REGULATION
AND LICENSURE**

STATE OF NEBRASKA ex rel. JON)
BRUNING, Attorney General,)
)
Plaintiff,)
)
vs.)
)
VENU G. MENON, M.D.,)
)
Defendant.)

AGREED SETTLEMENT

The Plaintiff and the Defendant, Venu G. Menon, M.D., in consideration of the mutual covenants and agreements contained herein, agree as follows:

1. The Defendant, Venu G. Menon, at all times relevant herein, has been the holder of a medical license (#16249), which was issued on February 14, 1983, by the Nebraska Department of Health and Human Services Regulation and Licensure ("Department").
2. The Defendant acknowledges receipt of a copy of the Petition for Disciplinary Action.
3. Before disciplinary measures may be taken against the Defendant's license, the Defendant is entitled to a hearing as provided by law. The Defendant waives the right to a hearing. The Defendant waives any right to judicial review of an order by the Department's Director who approves the terms of this Agreed Settlement.
4. No coercion, threats, or promises, other than those stated herein, were made to the Defendant to induce him to enter into this Agreed Settlement.
5. The Defendant acknowledges that he has read the Petition for Disciplinary Action filed by the Attorney General's Office. The Defendant admits the allegations of the Petition for Disciplinary Action.

6. The Defendant hereby voluntarily surrenders his medical license in the State of Nebraska for a minimum period of two (2) years in lieu of disciplinary proceedings.

7. The Defendant acknowledges that pursuant to Neb. Rev. Stat. § 71-161.11, reinstatement of the Defendant's licenses to practice as a physician in the State of Nebraska after the two year minimum of time is at the discretion of the Department and upon approval of the Board of Medicine and Surgery.

8. The Plaintiff and the Defendant consent to the Department's Director entering a final disciplinary order which finds that the allegations for the Petition for Disciplinary Action are true and grounds exist to accept the voluntary surrender of the Defendant's medical license in lieu of disciplinary proceedings.

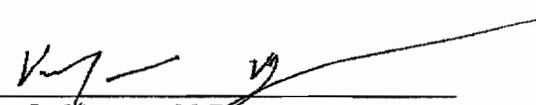
9. Any medical license now in the possession of the Defendant shall be surrendered to the Department *upon entry* of the Director's Order of Agreed Settlement.

10. The Attorney General's Office has given notice of this Agreed Settlement to the Board of Medicine and Surgery and has received their input in accordance with Neb. Rev. Stat. § 71-161.03.

11. If this Agreed Settlement is not approved by the Director, this Agreed Settlement shall become null and void and will not be admissible for any purpose at any hearing that may be held on this matter.

AGREED TO:

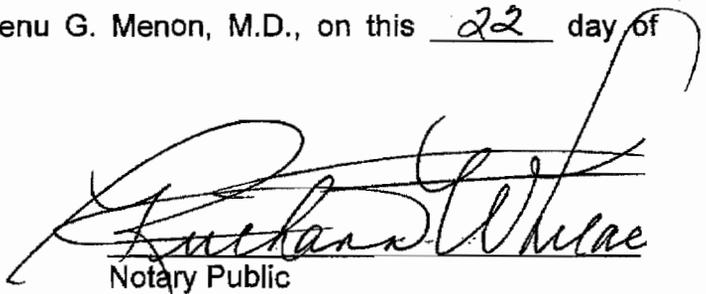
BY:



Venu G. Menon, M.D.
Defendant

State of Ohio)
County of Montgomery) ss.

Acknowledged before me by Venu G. Menon, M.D., on this 22 day of February, 2005.


Notary Public

RUTHANN WHITACRE
NOTARY PUBLIC-STATE OF OHIO
EXP: 10-28-2007

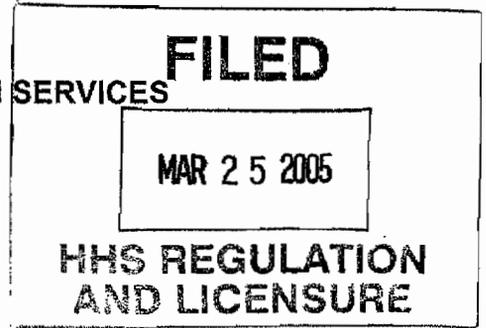
THE STATE OF NEBRASKA ex rel.
JON BRUNING, Attorney General
Plaintiff,

BY: JON BRUNING, #20351
Attorney General

BY: 
Bradley S. Shaff, #21083
Assistant Attorney General
2115 State Capitol
Lincoln, NE 68509
(402) 471-9658

Attorneys for Plaintiff.

THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
REGULATION AND LICENSURE
STATE OF NEBRASKA



STATE OF NEBRASKA ex rel. JON)
BRUNING, Attorney General,)
)
Plaintiff,)
)
vs.)
)
VENU G. MENON, M.D.,)
)
Defendant.)

PETITION FOR DISCIPLINARY
ACTION

CREDENTIALING DIVISION

APR 13 2005

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The Plaintiff alleges as follows:

ALLEGATIONS COMMON TO ALL CAUSES OF ACTION

1. Jurisdiction is based on Neb. Rev. Stat. §§ 71-150 and 71-1,102.
2. At all times relevant herein, the Defendant, Venu G. Menon, M.D., has been the holder of a license (#16249), which was issued on February 14, 1983, by the Nebraska Department of Health and Human Services Regulation and Licensure ("Department"), to practice as a physician.
3. The Department is the agency of the State of Nebraska authorized to enforce the provisions of the Uniform Licensing Law regulating physicians.
4. The Nebraska Board of Medicine and Surgery considered the investigation of this matter and made their recommendations to the Attorney General, which recommendations have been considered. Such matters are privileged pursuant to Neb. Rev. Stat. §§ 71-168.01(7) and 71-168.01(8).
5. Between approximately April 2000 to approximately February 2002, the Defendant was engaged in a contractual relationship with (CH) of McCook, NE, to provide professional anesthesia services.

6. On or about July 6, 2001, between approximately 12:15 p.m. and approximately 2:00 p.m., the Defendant attempted to intubate patient G.R. for administration of general anesthesia eight (8) to twelve (12) times without success. During the intubation attempts, the Defendant ordered Nurse S.B. to draw-up and administer numerous doses of succinylcholine, a paralytic agent. During the failed attempts, patient G.R.'s oxygen saturation levels dropped to between 30% and 40%. The Defendant failed to chart the orders to Nurse S.B. for the administration of succinylcholine, and failed to chart all oxygen saturation levels.

7. Between approximately April 2000 to approximately February 2002, the Defendant prescribed antibiotic medication for a patient without documenting in the patient's chart the medications prescribed or the purpose for which they were prescribed. The Defendant admitted in interviews conducted on September 10, 2003 and September 15, 2003, that he provided his girlfriend antibiotics by using the hospital prescription pads and that he did not keep any records of the medical care he provided to his girlfriend.

8. Between approximately April 2000 to approximately August 2001, the Defendant provided anesthesia services on numerous occasions for cataract procedures. In interviews of the Defendant conducted on September 10, 2003 and September 15, 2003, the Defendant admitted to re-using the same syringe on four (4) to five (5) patients each day in a three (3) to four (4) day time period. According to the Defendant, he continued the practice of reusing syringes on different patients until he was told by Nurse B. to stop.

9. Between approximately April 2000 to approximately February 2002, the Defendant failed to label each syringe he used to administer different medications during any given procedure. The Defendant admitted in interviews conducted on September 10,

2003 and September 15, 2003, that he regularly did not label the different syringes he used in each surgical case.

10. Between approximately April 2000 to approximately February 2002, the Defendant was observed by OR staff members, on more than one occasion, leaving a patient under his care, while the patient was under anesthesia, to wit:

A. On or about May 30, 2001, a surgical procedure had to be stopped when a patient started moving around. At the time, the Defendant was in the hallway outside the operating room talking with a student. The Defendant had to be asked to return to the operating room to administer more sedation so the surgical procedure could be completed.

B. On other occasions, after administering anesthesia, the Defendant left his patients in the operating room to drink coffee outside the operating room.

11. On approximately September 10, 2003 and approximately September 15, 2003, during interviews with a Department Investigator, the Defendant admitted to being approximately 20 feet away from patients under anesthesia and under his care while they were in the operating room.

12. Between approximately April 2000 to approximately February 2002, the Defendant failed to use filtered needles to withdraw medication from glass ampules.

13. Between approximately June 1, 2000 and approximately March 13, 2002, the Defendant wrote himself twenty six (26) prescriptions for Viagra.

14. On approximately September 10, 2003, the Defendant lied to a Department Investigator during an interview when he denied prescribing controlled substances for patients outside the hospital. A prescription audit obtained from F. Pharmacy showed three (3) prescriptions of Tylox (oxycodone with APAP 5/500), a controlled substance, had been written by the Defendant for patient J.B.

15. Between approximately October 1, 1994 and October 31, 1994, the Defendant's Clinical Privileges were revoked by Stouder Hospital in Troy, Ohio, for quality care concerns.

16. On or about February 21, 2002, CH informed Defendant that his contract was terminated due to the Defendant's substandard care and treatment practices.

17. The Defendant failed to report the above-described loss of privileges and termination to the Department within the mandatory thirty day reporting time period.

FIRST CAUSE OF ACTION

18. Paragraphs 1 through 17 are incorporated by reference.

19. Neb. Rev. Stat. § 71-147(10) provides that a Physician's license to practice his or her profession may be disciplined for unprofessional conduct.

20. Neb. Rev. Stat. § 71-148(19) defines unprofessional conduct as a failure to keep and maintain adequate records of treatment or service.

21. The Defendant's conduct as set out in paragraphs 6 and 7 above constitutes a failure to keep and maintain adequate records of treatment or service and is grounds for disciplinary action.

SECOND CAUSE OF ACTION

22. Paragraphs 1 through 21 are incorporated by reference.

23. Neb. Rev. Stat. § 71-147(10) provides that a Physician's license to practice his or her profession may be disciplined for unprofessional conduct.

24. Neb. Rev. Stat. § 71-148 defines unprofessional conduct as "any departure from or failure to conform to the standards of acceptable and prevailing practice of a profession or occupation or the ethics of the profession or occupation, regardless of whether a person, patient, or entity is injured...."

25. The Defendant's conduct, as alleged in paragraphs 8 through 12 constitutes a failure to conform to the standards of acceptable and prevailing practice of a profession and is grounds for disciplinary action.

THIRD CAUSE OF ACTION

26. Paragraphs 1 through 25 are incorporated by reference.

27. Neb. Rev. Stat. § 71-147(10) provides that a Physician's license to practice his or her profession may be disciplined for unprofessional conduct.

28. Neb. Rev. Stat. § 71-148 defines unprofessional conduct as "any departure from or failure to conform to the standards of acceptable and prevailing practice of a profession or occupation or the ethics of the profession or occupation, regardless of whether a person, patient, or entity is injured...."

29. American Medical Association Ethical Rule 8.19 states that "Physicians generally should not treat themselves ... Professional objectivity may be compromised when ... the physician is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered ... When treating themselves ... physicians may be inclined to treat problems that are beyond their expertise or training."

30. The Defendant's conduct, as alleged in paragraph 13, constitutes unprofessional conduct and is grounds for disciplinary action.

FOURTH CAUSE OF ACTION

31. Paragraphs 1 through 30 are incorporated by reference.

32. Neb. Rev. Stat. § 71-147(2) provides that a Physician's license to practice his or her profession may be disciplined for dishonorable conduct evidencing unfitness to meet the standards required for practice of the profession in this state.

33. The Defendant's conduct, as alleged in paragraph 14, constitutes dishonorable conduct evidencing unfitness and is grounds for disciplinary action.

FIFTH CAUSE OF ACTION

34. Paragraphs 1 through 33 are incorporated by reference.

35. Neb. Rev. Stat. § 71-147(20) provides that a Physician's license to practice his or her profession may be disciplined for failure to file a report required by Neb. Rev. Stat. § 71-168.

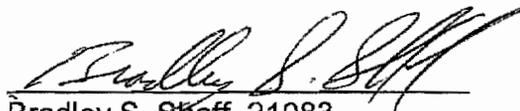
37. The Defendant's conduct, as alleged in paragraphs 15, 16 and 17, constitutes a failure to file a mandatory report within the thirty day time period and is grounds for disciplinary action.

PRAYER

WHEREFORE, the Plaintiff prays that the Chief Medical Officer set this matter for hearing, order appropriate disciplinary action pursuant to Neb. Rev. Stat. § 71-155, and tax the costs of this action to the Defendant.

STATE OF NEBRASKA, ex rel. JON
BRUNING, Attorney General,
Plaintiff,

BY: JON BRUNING, #20351
Attorney General

BY: 
Bradley S. Shaff, 21083
Assistant Attorney General
2115 State Capitol
Lincoln, NE 68509
(402) 471-3825

Attorneys for Plaintiff

IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO

VENU G. MENON, M.D. :
Appellant, : Case No. 06CV404
vs. :
STATE MEDICAL BOARD, : Judge Pfeiffer
Appellee.

AGREED JUDGMENT ENTRY TO VACATE

Rendered this _____ day of October, 2006

Based upon agreement of the parties and after consideration of the Motion to Remand filed in the Tenth District Court of Appeals Case No. 06AP-848, the State Medical Board of Ohio's December 15, 2005 Entry permanently revoking the license to practice medicine and surgery of Venu G. Menon, M.D. (Dr. Menon) is vacated and this Court's "Decision and Entry Reversing Appellee's Order Revoking Appellant's Medical License and Order of Remand" rendered August 11, 2006 is hereby **VACATED**. Further, it is hereby **ORDERED, ADJUDGED, AND DECREED**, that this matter is remanded to the State Medical Board of Ohio for the purpose of serving Dr. Menon with a copy of the August 10, 2005 Notice of Opportunity for Hearing by means of certified mail and to provide Dr. Menon with the opportunity to request and obtain a hearing in accordance with R.C. Chapter 119, on the underlying administrative matter.

JIM PETRO
Ohio Attorney General

Barbara Pfeiffer
BARBARA PFEIFFER 10/10/06
Assistant Attorney General
Counsel for Ohio State Medical Board

BEVERLY Y. PFEIFFER, JUDGE

Elizabeth Collis
ELIZABETH COLLIS *by b.jeff*
Counsel for Venu G. Menon, M.D.
10/10/06

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HEALTH & HUMAN

IN THE COURT OF COMMON PLEAS OF FRANKLIN COUNTY, OHIO
CIVIL DIVISION

SEP 18 2006

SERVICES SECTION

Vernon G. Menon, M.D., :
 Appellant, : Case No. 06CVF01-404
 -v- : JUDGE PFEIFFER
 State Medical Board of Ohio, :
 Appellee. :

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 CLERK OF COURTS

DECISION AND ENTRY GRANTING APPELLEE'S MOTION TO STAY EXECUTION
 OF JUDGMENT FILED AUGUST 22, 2006

Rendered this 12th day of September, 2006

PFEIFFER, J.

This matter is before the Court on Appellee the Ohio State Medical Board's (the "Board") Motion to Stay Execution of Judgment filed August 22, 2006. The Motion is opposed.

In this administrative appeal, the Court has recently issued a Decision reversing the Board's Order revoking Appellant's medical license, finding that Appellant never received the "Notice of Opportunity for Hearing." The Board now moves for a stay of that Decision during the pendency of the appeal to the Tenth District Court of Appeals. The Board contends that, under Civ. R. 62, the stay is automatic without the necessity for a bond. Appellant opposes the Motion arguing this Court has discretion to impose a stay.

Civ. R. 62 provides as follows:

(B) Stay upon appeal. When an appeal is taken the appellant may obtain a stay of execution of a judgment or any proceedings to enforce a judgment

by giving an adequate supersedeas bond. The bond may be given at or after the time of filing the notice of appeal. The stay is effective when the supersedeas bond is approved by the court.

(C) Stay in favor of government. When an appeal is taken by this state or political subdivision, or administrative agency of either, or by any officer thereof acting in his representative capacity and the operation or enforcement of the judgment is stayed, no bond, obligation or other security shall be required from the appellant.

The Ohio Supreme Court, in discussing the propriety of a trial court holding an evidentiary hearing on a political subdivision's motion for a stay, has held that:

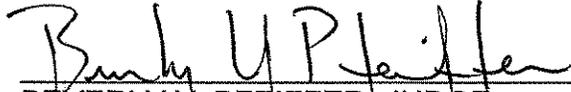
[p]ursuant to [Civ. R. 62], defendants-appellants are entitled to a stay of the judgment as a matter of right. The lone requirement of Civ. R. 62(B) is the giving of an adequate supersedeas bond. Civ. R. 62(C) makes this requirement unnecessary in this case, and [the trial court] has no discretion to deny the stay.

State ex rel. Ocasek v. Riley (1978), 54 Ohio St.2d 488, 490.

Since that ruling, the Supreme Court has continued to hold that a state agency is entitled to a stay as a matter of right under Civ. R. 62. See State ex rel. Geauga County Bd. of Comm'rs v. Milligan, 100 Ohio St. 3d 366, 2003-Ohio-6608; State ex rel. State Fire Marshal v. Curl, 87 Ohio St.3d 568, 2000-Ohio-248.

Appellant cites to Baker v. Ohio Bureau of Workers' Compensation (2000), 140 Ohio App.3d 766, in support of his contention that a trial court has discretion to grant a stay. Baker is distinguishable as that case involved a determination of entitlement to worker's compensation benefits, and R.C. 4123.512(H) mandates that such a determination is not stayed pending appeal.

Applying the clear and binding precedent, this Court has no discretion to otherwise grant the Board's request for a stay. Accordingly, the Motion is well-taken and GRANTED.


BEVERLY Y. PFEIFFER, JUDGE

Copies to:

Elizabeth Y. Collis
Counsel for Appellant

Barbara J. Pfeiffer
Counsel for Appellee

IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO

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Venu G. Menon, M.D.

Appellant-Appellee,

vs.

State Medical Board of Ohio,

Appellee-Appellant.

CASE NO. 06CVF-01-404

JUDGE PPFIEFFER

Notice of Appeal to Court of
Appeals from the August 11, 2006
Decision and Entry

NOTICE OF APPEAL

The State Medical Board of Ohio (the Appellee below) hereby appeals from the Court's August 11, 2006, Decision and Entry. A copy of the Decision and Entry is attached hereto.

Respectfully submitted,

JIM PETRO (0022096)
Attorney General

Barbara Pfeiffer
BARBARA PPFIEFFER (0029609)
Assistant Attorneys General
Health and Human Services Section
30 East Broad Street, 26th Floor
Columbus, Ohio 43215-3400
(614) 466-8600 - phone
(614) 466-6090 - fax

Attorney for Appellee-Appellant,
State Medical Board of Ohio

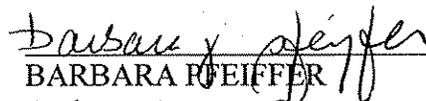
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CLERK OF COURTS

06APE--8-848

CERTIFICATE OF SERVICE

I hereby certify that a true and accurate copy of the foregoing Notice of Appeal was sent
by regular U.S. Mail this 22nd day of August 2006 to:

Beth Collis, Esq.
Collis, Smiles, & Collis, LLC
1650 Lake Shore Dr. Suite 225
Columbus, OH 43204



BARBARA PFEIFFER
Assistant Attorney General

IN THE COURT OF COMMON PLEAS OF FRANKLIN COUNTY, OHIO
CIVIL DIVISION

Vernon G. Menon, M.D., :
Appellant, : Case No. 06CVF01-404
-v- : JUDGE PFEIFFER
State Medical Board of Ohio, :
Appellee. :

DECISION AND ENTRY REVERSING APPELLEE'S ORDER REVOKING APPELLANT'S
MEDICAL LICENSE
AND
ORDER OF REMAND

Rendered this 11th day of August, 2006

PFEIFFER, J.

This case is before the Court on a R.C. 119.12 appeal from Appellee the State Medical Board's (the "Board") Order revoking Appellant's medical license.

On July 13, 2006, the Court issued a Decision narrowing the issue to whether Appellant was provided with an opportunity to request a hearing on the Board's intent to take action against his license. It is undisputed that the Board sent a "Notice of Opportunity for Hearing" via certified mail to Appellant's residence and that his wife signed the return receipt. However, Appellant averred that his wife never gave him the Notice. As Appellant submitted only a self-serving Affidavit to support his argument that he was not afforded an opportunity to request a hearing, the Court scheduled the matter for an evidentiary hearing on August 7, 2006.

At this hearing, Appellant again relied solely on his testimony. Appellant indicated that he and his wife are still married and reside together, but stated that she

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never gave him the Notice. Having had the opportunity to view Appellant, the Court finds his testimony to be truthful. Accordingly, the Court must find that he has rebutted the presumption of valid service of the notice. See Tripodi v. Liquor Control Commission (1970), 21 Ohio App.2d 110; New Co-Operative Co. v. Liquor Control Comm., Franklin App. No. 01AP-1124, 2002-Ohio-2244.

Through absolutely no fault of the Board, Appellant did not receive the Notice advising him of an opportunity to request a hearing. Pursuant to R.C. 119.07, the Board's Order must be REVERSED, and this matter is REMANDED for further proceedings consistent with this Decision. Costs to Appellant.


BEVERLY Y. PFEIFFER, JUDGE

Copies to:

Elizabeth Y. Collis
Counsel for Appellant

Barbara J. Pfeiffer
Counsel for Appellee

IN THE COURT OF COMMON PLEAS OF FRANKLIN COUNTY, OHIO
CIVIL DIVISION

Vernon G. Menon, M.D., :

Appellant, :

-v- :

State Medical Board of Ohio, :

Appellee. :

Case No. 06CVF01-404

JUDGE PFEIFFER

HEALTH & HUMAN

AUG 02 2006

STATE MEDICAL BOARD

ENTRY DENYING APPELLANT'S MOTION TO STAY MEDICAL BOARD ORDER
FILED JULY 5, 2006

This matter is before the Court on Appellant's Motion to Stay Medical Board Order filed July 5, 2006. The Motion is opposed.

This administrative appeal from Appellee's Order revoking Appellant's medical license was initiated on January 10, 2006. Appellant now moves the Court for a stay of Appellee's Order during the pendency of this appeal.

R.C. 119.12 provides:

[t]he filing of a notice of appeal shall not automatically operate as a suspension of the order of an agency. If it appears to the court that an unusual hardship to the appellant will result from the execution of the agency's order pending determination of the appeal, the court may grant a suspension and fix its terms.

(Emphasis added).

The revocation has already been in effect for over six months. Appellant provides no explanation for the lengthy delay in requesting a stay. His Motion is not well-taken and is DENIED.


BEVERLY Y. PFEIFFER, JUDGE

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Copies to:

Elizabeth Y. Collis
Counsel for Appellant

Barbara J. Pfeiffer
Counsel for Appellee

IN THE COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO

VENU G. MENON, M.D.,

Appellant,

vs.

STATE MEDICAL BOARD OF OHIO

Appellee.

]
] CASE NO. 06CVF-01-404
]
] JUDGE PFEIFFER
]
]
]
]

DECISION and NOTICE OF HEARING
Rendered this 12th day of July, 2006

PFEIFFER, J.

This case is before the Court on an appeal pursuant to R.C. 119.12. The relevant facts and procedural history are as follows.

On August 10, 2005, the State Medical Board (the "Board") issued a Notice of Opportunity for Hearing (the "Notice") to Appellant Venu G. Menon, M.D. Certified mail service of the Notice was made at Appellant's residence and signed for by Appellant's wife. There was no request for a hearing.

The Board proceeded without a hearing, and a Hearing Examiner prepared proposed findings. On December 14, 2005, the Board adopted the proposed findings and issued an Order permanently revoking Appellant's license to practice medicine (the "Order").

The U.S. Postal Service unsuccessfully attempted to deliver certified mail service of the Order to Appellant's residence on December 21, 2005. Appellant signed the certified mail receipt for delivery of the Order on January 9, 2006. Appellant filed this appeal on January 10, 2006.

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On January 25, 2006, the Board filed a Motion to Dismiss for Failure to Exhaust Administrative Remedies and Lack of Jurisdiction. On March 15, 2006, the Court denied the Motion to Dismiss noting that an issue existed as to when the fifteen day appeal period commenced. It was further noted that because reversal of the Board's Order was sought based upon the alleged failure of service, that issue should be argued in the briefs.

The Board contends that the Court lacks jurisdiction because Appellant failed to request a hearing and failed to file a timely appeal despite proper service of the Notice and the Order.

Appellant counters that the appeal was timely filed and that the Board's Order is contrary to law because the Board failed to provide him an opportunity to request a hearing and present evidence.

The Board argues that the Court lacks jurisdiction as the appeal was not filed within fifteen days of December 15, 2005, the date of mailing of the Order.

R.C. 119.09 provides that an agency's order shall be served as follows:

After such order is entered on its journal, the agency shall serve by certified mail, return receipt requested, upon the party affected thereby, a certified copy of the order and a statement of the time and method by which an appeal may be perfected.

Pursuant to R.C. 119.12, "notices of appeal shall be filed within fifteen days after the mailing of the notice of the agency's order."

The Order was sent via certified mail to Appellant's residence on December 15, 2005. The record reflects that the U.S. Postal Service did not attempt to deliver the Order until December 21, 2005. (Affidavit of Jacqueline Moore, the Board's Disciplinary Information Assistant, ¶¶5-10). A notice was left indicating that the document could be redelivered or picked up. (Id.). Appellant avers that on January 9, 2006, at a meeting

with his employers to discuss the status of his license, he was confronted with the Board's Order. (Appellant's affidavit ¶3, Ex. 2). He states that he did not receive the notification from the post office regarding a certified envelope, and that he did not receive the Order until he signed for it on January 9, 2006. (Appellant's affidavit, ¶9). Ms. Moore's affidavit confirms that the certified mail receipt was signed on January 9, 2006. (Moore affidavit, ¶10). The notice of appeal was filed the next day.

In Haddix v. Liquor Control Comm., Franklin App. No. 85AP-124, 1985 Ohio App. LEXIS 8109, the Court of Appeals addressed the issue of when the time period for the filing of an appeal from an agency's order began to run. The Court held that R.C. 119.09 contemplates that an agency will receive a signed return receipt or a refusal, and that due process was not complied with where the notice was returned as unclaimed.

As in Haddix, there is no evidence of either receipt or refusal of the certified mail service of the Order within the fifteen-day statutory time period for filing the appeal. There is no evidence that the December 21, 2005 post office notice apprised Appellant of the contents of the certified mail. The parties agree that Appellant signed for delivery of the Order on January 9, 2006 and that this appeal was filed the next day.

In accordance with Haddix, the Court finds that the appeal was timely filed, in that it was filed within fifteen days of the constitutionally required notice of the Order to Appellant.

The Board also argues that the Court lacks jurisdiction for the additional reason that Appellant failed to request a hearing and thereby failed to exhaust his administrative remedies. This claim was addressed and rejected in In the Matter of Turner Nursing

Home, Franklin App. No. 86AP-767, 1987 Ohio App. LEXIS 5729, where the Court stated as follows:

... A failure to request an adjudication hearing pursuant to R.C. 119.07 when afforded the opportunity to do so neither deprives a party adversely affected of his right of appeal from the adjudication order nor deprives the common pleas court of jurisdiction to hear the appeal. A failure to timely request a hearing constitutes a waiver of the right to an adjudication hearing before the administrative agency but it does not affect the right to appeal from such an order to a common pleas court. ...

In the case before us, it is uncontested that appellee failed to request an adjudicatory hearing pursuant to R.C. 119.07. Consequently appellee's only recourse was to file a timely appeal to the common pleas court, which appellee properly did. Therefore, although appellee's administrative remedies were waived by not requesting an administrative hearing, this waiver did not affect appellee's appeal to the common pleas court.

Turner was followed by the Tenth District Court of Appeals in Oak Grove Manor v. Ohio Department of Human Services, Franklin App. No. 01AP-71, 2001 Ohio App. LEXIS 4750. Relying on Turner, the Court of Appeals held that "the common pleas court erred in dismissing appellant's appeal upon the ground that the court lacked jurisdiction to hear the appeal because of appellant's failure to exhaust administrative remedies." For the foregoing reasons, the Court finds that it has jurisdiction of this appeal.

The final issue is whether Appellant was provided with an opportunity to request a hearing. The requirements for service of the notice are set forth in R.C. 119.07, which states as follows:

. . . in all cases in which section 119.06 of the Revised Code requires an agency to afford an opportunity for a hearing prior to the issuance of an order, the agency shall give notice to the party informing him of his right to a hearing. Notice shall be given by registered mail, return receipt requested, and shall include the charges or other reasons for the proposed action, the law or rule directly involved, and a statement

informing the party that he is entitled to a hearing if he requests it within thirty days of the time of mailing the notice....

...

The failure of an agency to give the notices for any hearing required by sections 119.01 to 119.13 of the Revised Code in the manner provided in this section shall invalidate any order entered pursuant to the hearing. (Emphasis added).

Applying R.C. 119.07, the court in Tripodi v. Liquor Control Commission (1970), 21 Ohio App.2d 110, held that a signed certified mail receipt creates a presumption of valid service and that the burden was on the permit holder to rebut the presumption. In Tripodi, the permit holder averred that he did not personally receive notice and that as far as he knew none of his employees did. However, the briefs of both parties referred to the signatory as an employee. The court found the presumption was not rebutted under such circumstances.

In New Co-Operative Co. v. Liquor Control Commission, 2002 Ohio 2244 the Tenth District Court of Appeals again confirmed that where notice is sent by certified mail, return receipt requested, and thereafter a signed receipt is returned to the sender, a prima facie case of delivery to the addressee is established. Valid service of process is presumed when the envelope is received by any person at the defendant's address; the recipient need not be an agent of the defendant. Id. at ¶8. The Court went on to state: "In determining whether appellant has sufficiently rebutted the presumption of valid service, the trial court may assess the credibility and competency of the submitted evidence of non-service. . . .An affidavit, by itself, stating that appellant did not receive service, may not be sufficient to rebut the presumption without any other evidence of a failure of service." Id. at ¶9.

As was the case in New Co-Operative, here the submitted evidence consists only of Appellant's affidavit that his wife signed the return receipt but did not give him or inform him of the notice. The record contains no other indication that service was ineffectual.

Because the credibility of the submitted evidence relating to the service of notice is at issue, this matter is schedule for an evidentiary hearing on July 26, 2006 at 9:00 a.m.


BEVERLY Y. PFEIFFER, JUDGE

Copies to:
Elizabeth Y. Collis, Counsel for Appellant
Barbara J. Pfeiffer, Counsel for Appellee

IN THE COURT OF COMMON PLEAS OF FRANKLIN COUNTY, OHIO
CIVIL DIVISION

HEALTH & HUMAN

Vernon G. Menon, M.D., :

MAR 20 2006

Appellant, :

Case No. 06CVF01-407

SERVICES SECTION

-v- :

JUDGE PFEIFFER

State Medical Board of Ohio, :

Appellee. :

CLERK OF COURTS

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FILED COURT

DECISION AND ENTRY DENYING APPELLANT'S MOTION FOR LEAVE TO FILE
NOTICE OF APPEAL AFTER THE FIFTEEN DAY DEADLINE
FILED JANUARY 10, 2006

AND

DECISION AND ENTRY DENYING APPELLEE'S MOTION TO DISMISS APPEAL FOR
FAILURE TO EXHAUST ADMINISTRATIVE REMEDIES AND LACK OF
JURISDICTION FILED JANUARY 25, 2006

AND

ENTRY GRANTING JOINT MOTION TO EXTEND BRIEFING SCHEDULE FILED
MARCH 10, 2006

AND

NOTICE OF AMENDED BRIEFING SCHEDULE

Rendered this 15th day of March, 2006

PFEIFFER, J.

This matter is before the Court on Appellant's Motion for Leave to File Notice of Appeal After the Fifteen Day Deadline filed January 10, 2006 and Appellee's Motion to Dismiss Appeal for Failure to Exhaust Administrative Remedies and Lack of Jurisdiction filed January 25, 2006. The relevant facts are as follows.

On August 10, 2005, Appellee State Medical Board of Ohio (the "Board") issued notice of its intent to take disciplinary action against Appellant's medical license due to a number of enumerated offenses. (the Board's Ex. 2C). Appellant was advised of his right to a hearing and informed that any hearing request needed to be received within

thirty days. (Id.). The notice was sent via certified mail to Appellant at his last known address of record. (Debra Jones Affidavit, ¶5). Appellant's spouse accepted service on August 13, 2005.

The Board never received a hearing request, and the disciplinary matter was referred to a Hearing Examiner, who issued proposed findings on November 30, 2005. The Board voted to accept the Hearing Examiner's findings and permanently revoke Appellant's medical license. The Board sent the final adjudication order to Appellant via certified mail on December 15, 2005. Jacqueline Moore, the Board's Disciplinary Information Assistant, avers that: "A review of the U.S. Postal Website indicates that the U.S. Post Office attempted to deliver the Board's December 15, 2005 Order on December 21, 2005 at 7:26 AM and that a notice was left indicating the document could be redelivered or picked up at the Post Office." (Jacqueline A. Moore Affidavit, ¶¶5-10). ¶10).

On January 9, 2006, inquiry was made, during a meeting between Appellant and his employers, as to the status of his medical license. Appellant indicated he was on probation until May 2006 and had last met with the Board in 2003. His employer then confronted him with the Board's order permanently revoking his medical license. (Appellant's Ex. 2). Appellant avers he had no knowledge of the Board's actions until this meeting. (Appellant's Affidavit, ¶3).

Appellant immediately contacted the Board and was informed by Ms. Moore that the August 10, 2005 notice had been signed for by his spouse. Appellant avers his spouse never gave him a copy of the notice. (Id. at ¶¶5-7). His Motion further alludes to the fact that he and his wife were estranged. Ms. Moore informed Appellant that the

final adjudication order had been mailed on December 15, 2005 and advised him to contact the local post office to determine the status of delivery. (Id. at ¶8). Appellant went to the post office on the same day and obtained the adjudication order. (Id. at ¶9). Ms. Moore verifies that Appellant did not sign the certified mail receipt until January 9, 2006. (Moore Aff., ¶10). The next day, Appellant initiated this administrative appeal.

Appellant now moves the Court for leave to pursue his appeal beyond the statutory fifteen-day filing period, while the Board seeks a dismissal arguing that the Court lacks subject matter jurisdiction as the appeal was not timely filed. Alternatively, the Board moves for a dismissal on the grounds that Appellant failed to exhaust his underlying administrative remedies by not requesting a hearing.

The Court will first address the issue of whether this appeal has been timely filed.

R.C. 119.12 states:

[a]ny party desiring to appeal shall file a notice of appeal with the agency setting forth the order appealed from and the grounds of the party's appeal. A copy of such notice of appeal shall also be filed by the appellant with the court. Unless otherwise provided by law relating to a particular agency, such notices of appeal shall be filed within fifteen days after the mailing of the notice of the agency's order as provided in this section.

When the right to appeal is conferred by statute, the appeal can be perfected only in the mode prescribed by statute. Ramsdell v. Ohio Civil Rights Comm. (1990), 56 Ohio St.3d 24, 27. The exercise of the right conferred is conditioned upon compliance with the accompanying mandatory requirements. Zier v. Bureau of Unemployment Comp. (1949), 151 Ohio St. 123, paragraph one of syllabus. One mandatory requirement is that filing of the notices must be done within the deadline established by

statute with both the court of common pleas and with the particular agency involved. Nivert v. Ohio Dep't of Rehab. & Corr. (1998), 84 Ohio St.3d 100, 102. After the prescribed time has passed, the trial court lacks jurisdiction to hear the appeal. Ramsdell, supra at 28.

The Court first notes that no authority exists for extension of this mandatory deadline, and thus, Appellant's Motion for Leave to File Notice of Appeal after the Deadline must be DENIED. A dispute does exist regarding the commencement date of the fifteen-day period. The Ohio Supreme Court has held that the timeframe does not commence to run until the agency, whose order is being appealed, fully complies with the procedural requirements set forth in R.C. 119.09. "Were we to hold otherwise, it is conceivable that an affected party could lose its right to appeal before receiving notice of an agency's decision, and thereby be deprived of its due process rights." Sun Ref. & Mktg. Co. v. Brennan (1987), 31 Ohio St.3d 306, 309.

R.C. 119.09 provides that:

* * * the agency shall serve by certified mail, return receipt requested, upon the party affected thereby, a certified copy of the order and a statement of the time and method by which an appeal may be perfected. A copy of such order shall be mailed to the attorneys or other representatives of record representing the party.

In Haddix v. Liquor Control Comm. (June 13, 1985), Franklin App. No. 85AP-124, the Tenth District Court of Appeals addressed the issue of when the twenty-one day appeal period from an order of the Liquor Control Commission began to run. The appellant filed the appeal more than twenty-one days from the mailing of the revocation order, and the common pleas court dismissed the action as being untimely. The Tenth District reversed, stating:

[w]e find that * * * R.C. 119.09 contemplates that appellee will receive a return receipt with a signature of receipt or refusal. In this case there is no evidence of either receipt or refusal, instead appellee admitted in oral arguments that the return receipt indicated that the notice was returned marked "unclaimed". Although R.C. 119.12 provides that the time for appeal starts running when the notice is mailed, we find that the requirements for due process as provided under the United States and Ohio Constitutions are not complied with under the facts of this case.

Id.

Here, the record reflects that the U.S. Post Office did not attempt to deliver the December 15, 2005 adjudication order until December 21, 2005, the delivery attempt was not successful, but notice was left that the document could be either redelivered or picked up. Appellant apparently argues that he did not receive this postal notification. There is no dispute that he did not sign the certified mail receipt until January 9, 2006, after expiration of the fifteen-day appeal period.

Upon careful consideration, the Court finds the Board has not demonstrated, at this stage of the proceedings, that the appeal is untimely. As to these facts, an issue exists regarding whether the fifteen-day appeal period can be deemed to have commenced on December 15, 2005. The Board had a statutory duty to serve its adjudication order via certified mail with return receipt requested. Here, one unsuccessful attempt at service was made in the middle of the fifteen-day period. The Board has not sufficiently addressed the issue of whether the postal notification, which placed the burden on Appellant to have the certified mail redelivered or picked-up, satisfied its statutory duty and due process. At this stage of the proceedings, the Court

cannot determine whether the appeal has been timely filed. Thus, it cannot be dismissed for lack of subject matter jurisdiction.

The Board alternatively argues that the Court lacks subject matter jurisdiction due to Appellant's failure to exhaust his administrative remedies, specifically, his failure to request a hearing in the underlying proceedings. However, the Tenth District has held that "[a] failure to request an adjudication hearing pursuant to R.C. 119.07 when afforded the opportunity to do so neither deprives a party adversely affected of his right of appeal from the eventual adjudication order pursuant to R.C. 119.12, nor deprives the common pleas court of jurisdiction to entertain such an appeal. Oak Grove Manor, Inc. v. Ohio Dep't of Human Servs., Franklin App. Nos. 01AP-71, 01AP-72, 2001-Ohio-4113.

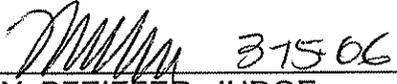
Therefore, Appellant's failure to request a hearing does not deprive the Court of subject matter jurisdiction of his appeal. Moreover, although valid service is presumed when the envelope is accepted by any person at the proper address, this presumption is "rebuttable by sufficient evidence demonstrating non-service." Grant v. Ivy (1980), 69 Ohio App.2d 40, 42; See also Tripodi v. Ohio Liquor Control Comm. (1970), 21 Ohio App. 2d 110, 112, 255 N.E.2d 294; New Coop. Co. v. Liquor Control Comm., Franklin App. No. 01AP-1124, 2002-Ohio-2244, at ¶8.

Applying that standard, Appellant has set forth sufficient evidence of non-service to at least withstand a dismissal. The Court is not, at this time, rendering a final decision on whether he was in fact served with the August 10, 2005 notice. This issue has been asserted as grounds for reversal of the Board's order and should be more properly argued in the parties' appellate briefs.

Based on the foregoing, the Board's Motion to Dismiss is not well-taken and is DENIED.

The parties have jointly moved the Court to extend the Briefing Schedule, asserting that they did not want to incur the expense of preparing their briefs until the Motion to Dismiss had been decided. Upon review, that Motion is well-taken and GRANTED, and the Briefing Schedule is hereby amended as follows:

Filing of Appellant's Brief	April 7, 2006
Filing of Appellee's Brief	April 21, 2006
Filing of Appellant's Reply Brief	April 28, 2006.


BEVERLY Y. PFEIFFER, JUDGE

Copies to:

Elizabeth Y. Collis
Counsel for Appellant

Barbara J. Pfeiffer
Counsel for Appellee

IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO

STATE MEDICAL BOARD
OF OHIO

2006 JAN 20 P 12: 59

Venu G. Menon, M.D.
610 Boxwood Court
Troy, Ohio 45373

Appellant, : Case No. _____

vs. : JUDGE _____

STATE MEDICAL BOARD OF OHIO :
77 South High Street, 16th floor
Columbus, Ohio 43215-6127

OHIO STATE MEDICAL BOARD

JAN 1 0 2006

Appellee

NOTICE OF APPEAL

Appellant, Venu G. Menon, M.D., pursuant to Ohio Revised Code Section 119.12 hereby appeals the final decision of the Ohio State Medical Board ("Appellee"), which **permanently revoked** his license to practice medicine in Ohio in its Adjudication Order (attached hereto) issued on December 14, 2005 and mailed to Appellant on December 15, 2005.

Appellant asserts that the decision of the Ohio State Medical Board is not

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STATE MEDICAL BOARD
OF OHIO

supported by reliable, probative and substantial evidence and is not in accordance with
2006 JAN 20 P 12: 59
law. In addition, Appellant asserts that Appellant never received a copy of the August
10, 2005 Notice of Opportunity for Hearing and therefore was not provided with an
opportunity to request a hearing with the Medical Board or to present any evidence on his
defense.

Respectfully submitted,

OHIO STATE MEDICAL BOARD

JAN 10 2006

Elizabeth Y. Collis (#0061961)
Collis, Smiles & Collis, LLC
1650 Lake Shore Drive, Suite 225
Columbus, Ohio 43204
(614) 486-3909; Fax (614) 486-2129
Attorney for Appellant,
Venu G. Menon, M.D.

Certificate of Service

STATE MEDICAL BOARD
OF OHIO

2006 JAN 20 P 12: 59

I certify that the *Notice of Appeal* was served upon Appellee, Ohio State Medical Board, 77 S. High Street, 17th Floor, Columbus, Ohio 43215 by hand delivery this 10th day of January, 2006 and upon and counsel for Appellee, Larry Pratt, Assistant Attorney General, Office of the Ohio Attorney General, Health and Human Services Section, 30 East Broad Street, 26th Floor, Columbus, Ohio 43215 by regular U.S. mail postage prepaid on this 10th day of January, 2006.

OHIO STATE MEDICAL BOARD

JAN 1 0 2006



Elizabeth Y. Collis (#0061961)



State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.med.ohio.gov

December 14, 2005

Venu Gopal Menon, M.D.
610 Boxwood Court
Troy, OH 45373

Dear Doctor Memon:

Please find enclosed a certified copy of the Findings, Order and Journal Entry approved and confirmed by the State Medical Board meeting in regular session on December 14, 2005.

Section 119.12, Ohio Revised Code, may authorize an appeal from this Order. Such an appeal must be taken to the Franklin County Court of Common Pleas.

Such an appeal setting forth the Order appealed from and the grounds of the appeal must be commenced by the filing of an original Notice of Appeal with the State Medical Board of Ohio and a copy with the Franklin County Court of Common Pleas. Any such appeal must be filed within fifteen (15) days after the mailing of this notice and in accordance with the requirements of Section 119.12 of the Ohio Revised Code.

Very truly yours,

Lance A. Talmage, M.D.
Secretary

LAT:jam
Enclosures

CERTIFIED MAIL NO. 7003 0500 0002 4334 8725
RETURN RECEIPT REQUESTED

Cc: Elizabeth Y. Collis, Esq.
CERTIFIED MAIL NO. 7003 0500 0002 4333 8718
RETURN RECEIPT REQUESTED

Mailed 12-15-05

CERTIFICATION

I hereby certify that the attached copy of the Findings, Order and Journal Entry approved by the State Medical Board, meeting in regular session on December 14, 2005, constitutes a true and complete copy of the Findings, Order and Journal Entry in the matter of Venu Gopal Menon, M.D., as it appears in the Journal of the State Medical Board of Ohio.

This Certification is made by the authority of the State Medical Board of Ohio in its behalf.



Lance A. Talmage, M.D.
Secretary

(SEAL)

December 14, 2005

Date

2005 NOV 30 P 12: 27

**PROPOSED FINDINGS AND PROPOSED ORDER
IN THE MATTER OF VENU GOPAL MENON, M.D.**

The Matter of Venu Gopal Menon, M.D., was reviewed by Sharon W. Murphy, Esq., Hearing Examiner for the State Medical Board of Ohio.

INTRODUCTION

Basis for the Review

1. By letter dated August 10, 2005, the State Medical Board of Ohio [Board] notified Venu Gopal Menon, M.D., that it had proposed to take disciplinary action against his certificate to practice medicine and surgery in Ohio. The Board's proposed action was based on allegations that Dr. Menon had violated conditions of probation imposed upon him by a May 14, 2003, Board Order, and that the Nebraska Health and Human Services System, Department of Regulation and Licensure, had taken action against Dr. Menon's certificate to practice in Nebraska. Finally, the Board advised Dr. Menon that he was entitled to a hearing if such hearing was requested within thirty days of the mailing of the notice of opportunity for hearing. (Exhibit 2C)
2. In accordance with Section 119.07, Ohio Revised Code, the notice of opportunity for hearing was sent via certified mail on August 11, 2005, return receipt requested. Proper service of the notice was documented. More than thirty days have elapsed since the mailing of the notice of opportunity for hearing, and Dr. Menon has not submitted a hearing request. (Exhibits 1, 2C, 3)

EVIDENCE EXAMINED

1. Exhibit 1: An October 4, 2005, Memorandum from Barbara A. Jacobs, Public Services Administrator, to Gregory Porter, Chief Hearing Officer.
2. Exhibit 2: An affidavit from Ms. Jacobs with attached certified copies of documents pertaining to Dr. Menon maintained by the Board, as follows:
 - a. Exhibit 2A: A December 11, 2002, Notice of Opportunity for Hearing.
 - b. Exhibit 2B: A May 14, 2003, Board Order.
 - c. Exhibit 2C: An August 10, 2005, Notice of Opportunity for Hearing, with copies of the certified mail receipt attached.

3. Exhibit 3: An affidavit from Debra L. Jones, Records and Renewal Officer for the Board.
4. Exhibit 4: An affidavit from Danielle C. Bickers, Compliance Officer for the Board.
5. Exhibit 5: An affidavit from Kathleen S. Petersen, Enforcement Attorney for the Board, with attached certified copies of documents pertaining to Dr. Menon, as follows:
 - a. Exhibit 5A: Documents maintained by the State of Iowa Board of Medical Examiners.
 - b. Exhibit 5B: Documents maintained by the State of Nebraska Health and Human Services System, Department of Regulation and Licensure.

SUMMARY OF THE EVIDENCE

All exhibits, even if not specifically mentioned, were thoroughly reviewed and considered by the Hearing Examiner prior to preparing this Proposed Findings and Proposed Order.

Background Information

1. In a previous hearing before the Board, Venu G. Menon, M.D., testified that he had graduated from medical school at the All India Institute of Medical Services. He further testified that, immediately after graduation, he had entered the Indian Army where he had served for approximately four and a half years. Nevertheless, a curriculum vita he submitted during that hearing listed service in the Indian Army from 1965 until 1967. Dr. Menon also testified at that hearing that, upon leaving the Indian Army, he had worked as a Casualty Medical Officer in England. Subsequently, he worked in Norway, Holland, and Sweden before coming to the United States in 1975. (Exhibit 2B at 9)

Moreover, during that hearing, Dr. Menon testified that he had completed two years of anesthesiology residency training at the Albert Einstein College of Medicine in New York and had practiced anesthesiology since that time. Nevertheless, a curriculum vita submitted during that hearing stated that Dr. Menon had completed one year of anesthesiology residency at the Albert Einstein College of Medicine and a second year at Louisville General Hospital in Louisville, Kentucky. (Exhibit 2B at 9)

Dr. Menon further testified that he had joined the United States Navy in 1977 and had remained on active duty until 1981, and in the reserves until 1994. After leaving active duty in 1981, Dr. Menon spent six to nine months working at the Nashville Veterans Administration [VA] Hospital. Subsequently, he worked simultaneously at the University of Iowa and at a VA Hospital. He remained in Iowa until 1986 when he accepted a position in Troy, Ohio. (Exhibit 2B at 9-10)

Termination of Dr. Menon's Privileges at Two Ohio Hospitals

2. For approximately seven years, Dr. Menon was a member of the medical staff at Stouder Memorial Hospital, a part of the Upper Valley Medical Center in Troy, Ohio. In October 1994, Dr. Menon's privileges at Stouder Memorial Hospital were terminated due to "quality of care concerns regarding the manner in which Dr. Menon completed medical records; [and] longstanding and continuing concerns regarding Dr. Menon's lack of availability during epidural anesthesia and on-call coverage." (Exhibit 2B at 13)
3. Moreover, Dr. Menon was a member of the medical staff at Piqua Memorial Medical Center, also a part of the Upper Valley Medical Center, from April 1987 until November 1998. Dr. Menon's privileges were terminated in November 1998 due to "quality of care concerns." (Exhibit 2B at 14)

Action by the Oklahoma State Board of Medical Licensure and Supervision

4. On April 16, 2002, Dr. Menon filed an application for reinstatement of his Oklahoma medical license, which had lapsed due to non-renewal. In his application for reinstatement, Dr. Menon denied that he had ever had hospital staff privileges removed or suspended or that he had ever surrendered hospital staff privileges while under investigation. (Exhibit 2B at 10-11)

By Order filed September 26, 2002, the Oklahoma State Board of Medical Licensure and Supervision [Oklahoma Board] denied Dr. Menon's application for reinstatement. The Oklahoma Board found that Dr. Menon had submitted false information on his reinstatement application and that he had previously lost privileges at two hospitals in Ohio based upon quality of care issues. The Oklahoma Board's substantive Conclusions of Law provided that:

[Dr. Menon had] failed to sustain his burden of proof that he [had] met all requirements for reinstatement of his medical license at this time, including but not limited to the requirements that he be of good moral character, that he have the ability to practice medicine and surgery with reasonable skill and safety, and that he is physically, mentally, professionally, and morally capable of practicing medicine and surgery in a manner reasonably acceptable to the [Oklahoma] Board.

(Exhibit 2B at 10-11)

May 14, 2003, Board Order

5. By letter dated December 11, 2002, the Board notified Dr. Menon that it had proposed to determine whether to take disciplinary action against his certificate to practice medicine and surgery in Ohio. The Board's proposed action was based on allegations pertaining to the Oklahoma Board's denial of Dr. Menon's application for reinstatement. On January 10, 2003, Dr. Menon submitted a written hearing request. On March 18, 2003, an

administrative hearing was held before a Hearing Examiner for the Board who subsequently issued a Report and Recommendation in The Matter of Venu G. Menon, M.D. (Exhibit 2A; Exhibit 2B at 7-23)

The Board considered the matter on May 14, 2003, at which time the Board made the following Findings of Fact:

On September 26, 2002, the Oklahoma State Board of Medical Licensure and Supervision filed an Order Denying Reinstatement of Medical License concerning Venu G. Menon, M.D. The Oklahoma Board found that Dr. Menon had submitted false information on his reinstatement application and that he had previously lost privileges at two hospitals in Ohio based upon quality of care issues.

(Exhibit 2B at 1, 20, 24-25)

Moreover, the Board concluded that the Oklahoma Board Order constituted “[a]ny of the following actions taken by the agency responsible for regulating the practice of medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or the limited branches of medicine in another jurisdiction, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual’s license to practice; acceptance of an individual’s license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand,” as that clause is used in Section 4731.22(B)(22), Ohio Revised Code. (Exhibit 2B at 20, 24-25)

Finally, the Board suspended Dr. Menon’s certificate to practice medicine and surgery in the State of Ohio for one year, but stayed the suspension. In addition, the Board placed probationary terms, conditions, and limitations on Dr. Menon’s certificate for a period of at least three years. (Exhibit 2B at 1-6, 24-25)

6. Among the terms and conditions imposed in the Board Order, Paragraph (A)(3) states that Dr. Menon “shall submit quarterly declarations under penalty of Board disciplinary action or criminal prosecution, stating whether there has been compliance with all the conditions of this Order.” (Exhibit 2B at 4)

Paragraph (A)(5) of the Board Order states that Dr. Menon’s “monitoring physician shall provide the Board with reports on the monitoring of Dr. Menon and his medical practice, and on the review of Dr. Menon’s patient charts” and that Dr. Menon “shall ensure that the reports are forwarded to the Board on a quarterly basis and are received in the Board’s offices no later than the due date for Dr. Menon’s quarterly declaration.” (Exhibit 2B at 4-5)

Paragraph (A)(9) of the Ohio Board Order states that Dr. Menon “shall notify the Board of any action taken against a certificate to practice held by Dr. Menon in any other state.” (Exhibit 2B at 5)

Action by the State of Iowa Board of Medical Examiners

7. On September 15, 2004, the State of Iowa Board of Medical Examiners [Iowa Board] issued a Final Order in the Matter of the Statement of Charges Against Venu G. Menon, M.D., Respondent [Iowa Board Order]. The Iowa Board action was based upon the prior action of the Oklahoma Board against Dr. Menon’s certificate to practice in that state. Pursuant to the Iowa Board Order, Dr. Menon’s license to practice medicine and surgery in the State of Iowa was indefinitely suspended with specific requirements for reinstatement. (Exhibit 5A)

Action by the Nebraska Health and Human Services System, Regulation and Licensure

8. On March 25, 2005, the Nebraska Department of Health and Human Services System, Regulation and Licensure, [Nebraska Department of HHS Regulation and Licensure] issued a Petition for Disciplinary Action against Dr. Menon. Among the factual allegations set forth in the Petition for Disciplinary Action are the following:
 - a. “Between approximately April 2000 to approximately February 2002, [Dr. Menon was] engaged in a contractual relationship with (CH) of McCook, [Nebraska], to provide professional anesthesia services.”
 - b. “On or about July 6, 2001, between approximately 12:15 p.m. and approximately 2:00 p.m., [Dr. Menon] attempted to intubate Patient G.R. for administration of general anesthesia eight (8) to twelve (12) times without success. During the intubation attempts, [Dr. Menon] ordered Nurse S.B. to draw-up and administer numerous doses of succinylcholine, a paralytic agent. During the failed attempts, Patient G.R.’s oxygen saturation levels dropped to between 30% and 40%. [Dr. Menon] failed to chart the orders to Nurse S.B. for the administration of succinylcholine, and failed to chart all oxygen saturation levels.”
 - c. “Between approximately April 2000 to approximately February 2002, [Dr. Menon] prescribed antibiotic medication for a patient without documenting in the patient’s chart the medications prescribed or the purpose for which they were prescribed. [Dr. Menon] admitted in interviews conducted on September 10, 2003 and September 15, 2003, that he provided his girlfriend antibiotics by using hospital prescription pads and that he did not keep any records of the medical care he provided to his girlfriend.”
 - d. “Between approximately April 2000 to approximately August 2001, [Dr. Menon] provided anesthesia services on numerous occasions for cataract procedures. In

interviews of [Dr. Menon] conducted on September 10, 2003 and September 15, 2003, [Dr. Menon] admitted to re-using the same syringe on four (4) to five (5) patients each day in a three (3) to four (4) day time period. According to Dr. Menon, he continued the practice of reusing syringes on different patients until he was told by Nurse B. to stop.”

- e. “Between approximately April 2000 to approximately February 2002, [Dr. Menon] failed to label each syringe he used to administer different medications during any given procedure. [Dr. Menon] admitted in interviews conducted on September 10, 2002 and September 15, 2003, that he regularly did not label syringes he used in each surgical case.”
- f. “Between approximately April 2000 to approximately February 2002, [Dr. Menon] was observed by OR staff members, on more than one occasion, leaving a patient under his care, while the patient was under anesthesia, to wit:
 - “A. On or about May 30, 2001, a surgical procedure had to be stopped when a patient started moving around. At the time, [Dr. Menon] was in the hallway outside the operating room talking with a student. [Dr. Menon] had to be asked to return to the operating room to administer more sedation so the surgical procedure could be completed.
 - “B. On other occasions, after administering anesthesia, [Dr. Menon] left his patients in the operating room to drink coffee outside the operating room.”
- g. “On approximately September 10, 2003 and approximately September 15, 2003, during interviews with a Department Investigator, [Dr. Menon] admitted to being approximately 20 feet away from patients under anesthesia and under his care while they were in the operating room.”
- h. “Between approximately June 1, 2000 and approximately March 13, 2002, [Dr. Menon] wrote himself twenty six (26) prescriptions for Viagra.”
- i. “On approximately September 10, 2003, [Dr. Menon] lied to a Department Investigator during an interview when [Dr. Menon] denied prescribing controlled substances for patients outside the hospital. A prescription audit obtained from F. Pharmacy showed three (3) prescriptions of Tylox (oxycodone with APAP 5/500), a controlled substance, had been written by [Dr. Menon] for patient J.B.”
- j. “On or about February 21, 2002, CH informed [Dr. Menon] that his contract was terminated due to [Dr. Menon’s] substandard care and treatment practices.”

(Exhibit 5B at 6-9)

9. On March 25, 2005, the Nebraska Department of HHS Regulation and Licensure filed an Agreed Settlement, signed by Dr. Menon on February 22, 2005. In the Agreed Settlement, Dr. Menon voluntarily surrendered his license to practice medicine in the State of Nebraska for a minimum period of two years, in lieu of disciplinary proceedings. Moreover, by signing the Agreed Settlement, Dr. Menon admitted to the allegations contained in the Petition for Disciplinary Action. Further, Dr. Menon consented to having the Nebraska Department of HHS Regulation and Licensure issue a final disciplinary order, in which the allegations in the Petition for Disciplinary Action were determined to be true. (Exhibit 5B at 3-5)

On April 6, 2005, the Director of the Nebraska Department of HHS Regulation and Licensure adopted the Agreed Settlement and the admitted factual allegations contained in the Petition for Disciplinary Action. (Exhibit 5B at 2)

Dr. Menon's Failure to Comply with the Board's May 14, 2003, Conditions of Probation

10. At the time the August 10, 2005, notice of opportunity for hearing was issued, Dr. Menon remained subject to the probationary terms and conditions of the May 14, 2003, Board Order. Despite the requirements of Paragraph (A)(3) of that Order, Dr. Menon failed to submit quarterly declarations that were due in February and August 2005. Further, although he submitted a quarterly declaration due on May 1, 2005, he did not complete the quarterly declaration until May 30, 2005, and the Board did not receive it until June 6, 2005. (Exhibit 4)

Moreover, despite the requirements of Paragraph (A)(5) of the May 14, 2003, Board Order, Dr. Menon failed to ensure that his monitoring physician forwarded to the Board the quarterly reports that were due in February, May, and August 2005. (Exhibit 4)

Finally, despite the requirements of Paragraph (A)(9) of the May 14, 2003, Board Order, Dr. Menon failed to notify the Board of the actions taken against his certificates to practice in the States of Iowa and Nebraska. (Exhibit 4)

PROPOSED FINDINGS

1. On May 14, 2003, the Board issued an Order In the Matter of Venu G. Menon, M.D. In the May 14, 2003, Board Order, the Board made the following Findings of Fact:

On September 26, 2002, the Oklahoma State Board of Medical Licensure and Supervision [Oklahoma Board] filed an Order Denying Reinstatement of Medical License concerning Venu G. Menon, M.D. The Oklahoma Board found that Dr. Menon had submitted false information on his reinstatement application and that he had previously lost privileges at two hospitals in Ohio based upon quality of care issues.

Moreover, the Board concluded that the Order of the Oklahoma Board constituted “[a]ny of the following actions taken by the agency responsible for regulating the practice of medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or the limited branches of medicine in another jurisdiction, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual’s license to practice; acceptance of an individual’s license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand,” as that clause is used in Section 4731.22(B)(22), Ohio Revised Code.

Finally, the Board suspended Dr. Menon’s certificate to practice medicine and surgery in the State of Ohio for one year, but stayed the suspension. In addition, the Board placed probationary terms, conditions, and limitations on Dr. Menon’s certificate to practice for a period of at least three years.

2. At the time the August 10, 2005, notice of opportunity for hearing was issued, Dr. Menon remained subject to the probationary terms and conditions imposed by the May 14, 2003, Board Order. Among those probationary terms and conditions, Paragraph (A)(3) states that Dr. Menon “shall submit quarterly declarations under penalty of Board disciplinary action or criminal prosecution, stating whether there has been compliance with all the conditions of this Order.” Nevertheless, despite the requirements of Paragraph (A)(3), Dr. Menon failed to submit quarterly declarations that were due in February and August 2005. Further, although he submitted a quarterly declaration due on May 1, 2005, he did not complete the quarterly declaration until May 30, 2005, and the Board did not receive it until June 6, 2005.

In addition, Paragraph (A)(5) of the May 14, 2003, Board Order states that Dr. Menon’s “monitoring physician shall provide the Board with reports on the monitoring of Dr. Menon and Dr. Menon’s medical practice, and on the review of Dr. Menon’s patient charts” and that Dr. Menon “shall ensure that the reports are forwarded to the Board on a quarterly basis and are received in the Board’s offices no later than the due date for Dr. Menon’s quarterly declaration.” Nevertheless, despite the requirements of Paragraph (A)(5), Dr. Menon failed to ensure that his monitoring physician forwarded to the Board quarterly reports that were due in February, May, and August 2005.

Furthermore, Paragraph (A)(9) of the May 14, 2003, Board Order states that Dr. Menon “shall notify the Board of any action taken against a certificate to practice held by Dr. Menon in any other state.” Nevertheless, despite the requirements of Paragraph (A)(9), Dr. Menon failed to notify the Board of actions taken against his certificates to practice in the States of Iowa and Nebraska.

3. On April 6, 2005, the Director of the Nebraska Department of Health and Human Services System, Regulation and Licensure, [Nebraska Department of HHS Regulation and Licensure] adopted an Agreed Settlement between the Nebraska Department of HHS

Regulation and Licensure and Dr. Menon. In the Agreed Settlement, Dr. Menon admitted the truth of allegations made by the Nebraska Department of HHS Regulation and Licensure in a Petition for Disciplinary Action against Dr. Menon. The factual allegations pertained to care Dr. Menon had provided during the period from approximately 2000 through 2002, while he had been engaged in a contractual relationship to provide professional anesthesia services in Nebraska. The allegations that Dr. Menon admitted to be true included the following:

- a. During a period of approximately two hours on or about July 6, 2001, Dr. Menon attempted to intubate a patient for administration of general anesthesia. Dr. Menon attempted intubation approximately eight to twelve times without success. During the intubation attempts, Dr. Menon ordered a nurse to administer numerous doses of succinylcholine, a paralytic agent, but Dr. Menon failed to document those orders. Moreover, during the failed attempts at intubation, the patient's oxygen saturation levels dropped to between 30% and 40%, but Dr. Menon failed to chart all oxygen saturation levels.
- b. During an approximate two-year period, Dr. Menon prescribed antibiotic medication for his girlfriend without documenting the medications prescribed or the purpose for which they were prescribed. Dr. Menon prescribed the antibiotics using hospital prescription pads.
- c. Dr. Menon reused the same syringe on four to five patients each day, over a three to four day period. Dr. Menon only stopped reusing syringes when told to do so by a nurse.
- d. During an approximate two-year period, Dr. Menon did not regularly label syringes he used in each surgical case.
- e. Operating department staff members observed Dr. Menon, on more than one occasion, leaving a patient under his care while the patient was under anesthesia. In one case, a surgical procedure had to be stopped when the patient started moving around. At the time, Dr. Menon was in the hallway outside the operating room. Dr. Menon had to be asked to return to the operating room and to administer more sedation before the surgical procedure could be completed. On other occasions, after administering anesthesia, Dr. Menon left his patients in the operating room to drink coffee outside the operating room.
- f. Dr. Menon wrote twenty-six prescriptions for Viagra for himself.
- g. Dr. Menon lied to a department investigator regarding prescriptions he had written for controlled substances.

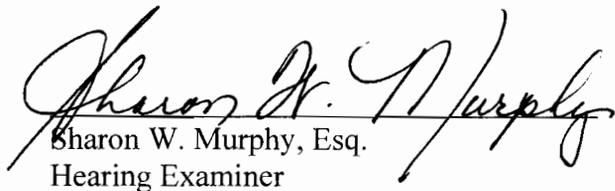
- h. On or about February 21, 2002, Dr. Menon's contract to provide anesthesia services was terminated due to Dr. Menon's substandard care and treatment practices.
4. Dr. Menon's conduct, as described in the Proposed Findings, Paragraph 2, constitutes "[v]iolation of the conditions of limitation placed by the board upon a certificate to practice," as that clause is used in Section 4731.22(B)(15), Ohio Revised Code.
5. The Nebraska Department of Health and Human Services Regulation and Licensure Order on Agreed Settlement as described in the Proposed Findings, Paragraph 3, constitutes "[a]ny of the following actions taken by the agency responsible for regulating the practice of medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or the limited branches of medicine in another jurisdiction, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual's license to practice; acceptance of an individual's license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand," as that clause is used in Section 4731.22(B)(22), Ohio Revised Code.

PROPOSED ORDER

It is hereby ORDERED that:

The certificate of Venu Gopal Menon, M.D., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED.

This Order shall become effective immediately upon mailing of notification of approval by the Board.


Sharon W. Murphy, Esq.
Hearing Examiner



State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.med.ohio.gov

August 10, 2005

Venu Gopal Menon, M.D.
610 Boxwood Ct.
Troy, OH 45373

Dear Doctor Menon:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio [Board] intends to determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery, or to reprimand you or place you on probation for one or more of the following reasons:

- (1) By letter dated December 11, 2002, the Board notified you that it proposed to determine whether or not to limit, revoke, permanently revoke, or suspend your certificate, refuse to issue or reinstate your certificate, or to reprimand you or place you on probation based on allegations that the Oklahoma State Board of Medical Licensure and Supervision had filed an "Order Denying Reinstatement of [Dr. Menon's] Medical License" [Oklahoma Board Order]. The Board alleged that the Oklahoma Board Order constituted "[a]ny of the following actions taken by the agency responsible for regulating the practice of medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or the limited branches of medicine in another jurisdiction, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual's license to practice; acceptance of an individual's license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand," as that clause is used in Section 4731.22(B)(22), Ohio Revised Code.

On or about January 10, 2003, you submitted a written hearing request, and the matter came to hearing in front of an Attorney Hearing Examiner for the Board on March 18, 2003. On or about April 14, 2003, the Attorney Hearing Examiner issued a Report and Recommendation In The Matter of Venu G. Menon, M.D. Said Report and Recommendation included the following finding of fact:

On September 26, 2002, the Oklahoma State Board of Medical Licensure and Supervision filed an Order Denying Reinstatement of Medical License concerning Venu G. Menon, M.D. The Oklahoma Board found that Dr. Menon had submitted false information on his reinstatement application and that he had

MAILED 8-11-05

previously lost privileges at two hospitals in Ohio based upon quality of care issues.

- (2) On or about May 14, 2003, the Board entered an Order that adopted the Hearing Examiner's Report and Recommendation, suspended your certificate to practice medicine and surgery in the State of Ohio for one year, stayed said suspension, and placed probationary terms, conditions, and limitations on your certificate to practice medicine and surgery for a period of at least three years. A copy of the Board's May 14, 2003, Entry of Order [Ohio Board Order] is attached hereto and fully incorporated herein.
 - (a) Paragraph (A)(3) of the Ohio Board Order states that you "shall submit quarterly declarations under penalty of Board disciplinary action or criminal prosecution, stating whether there has been compliance with all the conditions of this Order." Despite the requirements of Paragraph (A)(3), you failed to submit quarterly declarations that were due in February of 2005 and August of 2005. Further, although you submitted a quarterly declaration in May of 2005, the declaration, which was due on May 1, 2005, was not completed by you until May 30, 2005, and not received by the Board until June of 2005.
 - (b) Paragraph (A)(5) of the Ohio Board Order states that your "monitoring physician shall provide the Board with reports on the monitoring of [you] and [your] medical practice, and on the review of [your] patient charts" and that you "shall ensure that the reports are forwarded to the Board on a quarterly basis and are received in the Board's offices no later than the due date for [your] quarterly declaration." Despite the requirements of Paragraph (A)(5), you failed to ensure that your monitoring physician forwarded to the Board the quarterly reports that were due in February of 2005, May of 2005, and August of 2005.
 - (c) Paragraph (A)(9) of the Ohio Board Order states that you "shall notify the Board of any action taken against a certificate to practice held by [you] in any other state." Despite the requirements of Paragraph (A)(9), you failed to notify the Board of the following actions taken against your certificates to practice in other states:
 - (i) On or about September 15, 2004, the Board of Medical Examiners of the State of Iowa issued a Final Order In The Matter Of The Statement Of Charges Against Venu G. Menon, M.D., Respondent [Iowa Board Order]. Pursuant to the Iowa Board Order, your license to practice medicine and surgery in the State of Iowa was indefinitely suspended with specific requirements for reinstatement. A copy of the Iowa Board Order is attached hereto and incorporated herein.

- (ii) On or about April 6, 2005, the Department of Health and Human Services Regulation and Licensure for the State of Nebraska [Nebraska Department of HHS Regulation and Licensure], issued an order adopting an Agreed Settlement between you and the Nebraska Department of HHS Regulation and Licensure, whereby you voluntarily surrendered your medical license in the State of Nebraska for a minimum period of two years in lieu of disciplinary proceedings. A copy of the Nebraska Department of HHS Regulation and Licensure Order on Agreed Settlement and Petition for Disciplinary Action are attached hereto and incorporated herein.

- (3) On or about February 22, 2005, you signed an Agreed Settlement with the Nebraska Department of HHS Regulation and Licensure, whereby you voluntarily surrendered your medical license in the State of Nebraska for a minimum period of two years in lieu of disciplinary proceedings. By signing said Agreed Settlement, you admitted to the allegations contained in the Nebraska Petition for Disciplinary Action. Further, you consented to having the Director of the Nebraska Department of HHS Regulation and Licensure issue a final disciplinary order, in which the allegations in the Nebraska Petition for Disciplinary Action were determined to be true. On or about April 6, 2005, the Director of the Nebraska Department of HHS Regulation and Licensure adopted the Agreed Settlement and the admitted factual allegations contained in the Petition for Disciplinary Action. The allegations of fact to which you admitted are fully set forth in the attached Nebraska Department of HHS Regulation and Licensure Order on Agreed Settlement and Petition for Disciplinary Action. Among the admitted factual allegations are the following:
 - (a) Between approximately April 2000 to approximately February 2002, [you were] engaged in a contractual relationship with (CH) of McCook, [Nebraska], to provide professional anesthesia services.

 - (b) On or about July 6, 2001, between approximately 12:15 p.m. and approximately 2:00 p.m., [you] attempted to intubate patient G.R. for administration of general anesthesia eight (8) to twelve (12) times without success. During the intubation attempts, [you] ordered Nurse S.B. to draw-up and administer numerous doses of succinylcholine, a paralytic agent. During the failed attempts, patient G.R.'s oxygen saturation levels dropped to between 30% and 40%. [You] failed to chart the orders to Nurse S.B. for the administration of succinylcholine, and failed to chart all oxygen levels.

 - (c) Between approximately April 2000 to approximately February 2002, [you] prescribed antibiotic medication for a patient without documenting in the patient's chart the medications prescribed or the purpose for which they were prescribed. [You] admitted in interviews conducted on September

10, 2003 and September 15, 2003, that [you] provided [your] girlfriend antibiotics by using hospital prescription pads and that [you] did not keep any records of the medical care [you] provided to [your] girlfriend.

- (d) Between approximately April 2000 to approximately August 2001, [you] provided anesthesia services on numerous occasions for cataract procedures. In interviews ... conducted on September 10, 2002 and September 15, 2003, [you] admitted to re-using the same syringe on four (4) to five (5) patients each day in a three (3) to four (4) day time period. [You admitted you] continued the practice of reusing syringes on different patients until [you were] told by Nurse B. to stop.
- (e) Between approximately April 2000 to approximately February 2002, [you] failed to label each syringe [you] used to administer different medications during any given procedure. [You] admitted in interviews conducted on September 10, 2002 and September 15, 2003, that [you] regularly did not label syringes [you] used in each surgical case.
- (f) Between approximately April 2000 to approximately February 2002, [you were] observed by OR staff members, on more than one occasion, leaving a patient under [your] care, while the patient was under anesthesia, to wit:
 - (i) On or about May 30, 2001, a surgical procedure had to be stopped when a patient started moving around. At the time, [you were] in the hallway outside the operating room talking with a student. [You] had to be asked to return to the operating room to administer more sedation so the surgical procedure could be completed.
 - (ii) On other occasions, after administering anesthesia, [you] left [your] patients in the operating room to drink coffee outside the operating room.
- (g) On approximately September 10, 2003 and approximately September 15, 2003, during interviews with a Department Investigator, [you] admitted to being approximately 20 feet away from patients under anesthesia and under [your] care while they were in the operating room.
- (h) Between approximately April 2000 to approximately February 2002, [you] failed to use filtered needles to withdraw medication from glass ampules.
- (i) Between approximately June 1, 2000 and approximately March 13, 2002, [you] wrote [yourself] twenty six (26) prescriptions for Viagra.

- (j) On approximately September 10, 2003, [you] lied to a Department Investigator during an interview when [you] denied prescribing controlled substances for patients outside the hospital. A prescription audit obtained from F. Pharmacy showed three (3) prescriptions of Tylox (oxycodone with APAP 5/500), a controlled substance, had been written by [you] for patient J.B.

- (k) On or about February 21, 2002, CH informed [you] that [your] contract was terminated due to [your] substandard care and treatment practices.

Your acts, conduct, and/or omissions as alleged in paragraph (2) above, individually and/or collectively, constitute a “[v]iolation of the conditions of limitation placed by the board upon a certificate to practice,” as that clause is used in Section 4731.22(B)(15), Ohio Revised Code.

The Nebraska Department of Health and Human Services Regulation and Licensure Order on Agreed Settlement as alleged in paragraph (3) above constitutes “[a]ny of the following actions taken by the agency responsible for regulating the practice of medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or the limited branches of medicine in another jurisdiction, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual's license to practice; acceptance of an individual's license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand,” as that clause is used in Section 4731.22(B)(22), Ohio Revised Code.

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty days of the time of mailing of this notice.

You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

In the event that there is no request for such hearing received within thirty days of the time of mailing of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery or to reprimand you or place you on probation.

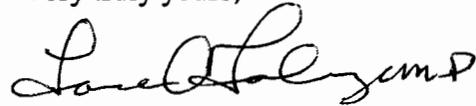
Venu Gopal Menon, M.D.

Page 6

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, provides that “[w]hen the board refuses to grant a certificate to an applicant, revokes an individual’s certificate to practice, refuses to register an applicant, or refuses to reinstate an individual’s certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a certificate to practice and the board shall not accept an application for reinstatement of the certificate or for issuance of a new certificate.”

Copies of the applicable sections are enclosed for your information.

Very truly yours,

A handwritten signature in black ink, appearing to read "Lance A. Talmage", written in a cursive style.

Lance A. Talmage, M.D.
Secretary

LAT/blt
Enclosures

CERTIFIED MAIL # 7003 0500 0002 4340 7452
RETURN RECEIPT REQUESTED

Elizabeth Y. Collis, Esq.
1650 Lake Shore Drive, Suite 180
Columbus, OH 43204

CERTIFIED MAIL # 7003 0500 0002 4340 7445
RETURN RECEIPT REQUESTED

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF IOWA

IN THE MATTER OF THE STATEMENT OF CHARGES AGAINST

VENU G. MENON, M.D., RESPONDENT

FILE No. 02-02-780

FINAL ORDER

BE IT REMEMBERED:

DATE: September 15, 2004.

1. Respondent was issued license number 23671 to practice medicine and surgery in Iowa on July 1, 1983.
2. Respondent's Iowa medical license is active and will next expire on September 1, 2005.
3. The Board has jurisdiction in this matter pursuant to Iowa Code Chapters 147, 148 and 272C.
4. The Board filed a Statement of Charges against Respondent's Iowa medical license on May 29, 2003. The Board charged Respondent with being disciplined by the medical licensing authority of another state in violation of the laws and rules governing the practice of medicine in Iowa.

5. A contested case hearing was held on the Statement of Charges before a three member panel of the Board on July 6, 2004.

6. A Proposed Decision and Order of the Panel (Proposed Decision) was issued by the Board on August 9, 2004.

7. A copy of the Proposed Decision was delivered to counsel for the State of Iowa, Heather Adams, Assistant Attorney General, on August 10, 2004.

8. A copy of the Proposed Decision was delivered to the Respondent via certified mail on August 13, 2004.

9. No appeal of the Proposed Decision was filed pursuant to Iowa Code Chapter 17A and 653 IAC 12.50.

THEREFORE IT IS HEREBY ORDERED that the Proposed Decision in this matter, a copy of which is attached as Exhibit A, is a **FINAL DECISION** of the Board and the Decision and Order outlined therein is a **FINAL ORDER OF THE BOARD**.



Bruce L. Hughes, M.D., Chairperson
Iowa Board of Medical Examiners
400 SW 8th Street, Suite C
Des Moines, IA 50309-4686

September 15, 2004

Date

Exhibit A

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF IOWA

IN THE MATTER OF THE)	DIA NO. 03DPHMB010
STATEMENT OF CHARGES AGAINST:)	CASE NOS. 02-2002-0780
)	
)	
venu G. MENON, M.D.)	PROPOSED DECISION AND
)	ORDER OF THE PANEL
Respondent)	
)	

On May 29, 2003 the Iowa Board of Medical Examiners (Board) filed a Statement of Charges against Venu G. Menon, M.D. (Respondent) alleging that the Respondent's license to practice medicine and surgery had been disciplined by the medical licensing authority of another state. The Complaint further alleged that the Iowa Board was authorized to take disciplinary action against the Respondent pursuant to Iowa Code section 148.6(2)(d)(2003).

An original Notice of Hearing was issued setting the hearing for July 9, 2003. The hearing was continued three times, twice at the Respondent's request. The Respondent's third request for continuance, filed on May 29, 2004, was denied. The hearing was held on July 6, 2004 at 8:40 a.m. The Respondent did not appear for the hearing and was not represented by counsel. The hearing was held before a panel of the Board: Bruce Hughes, M.D., Chairperson; Susan Johnson, M.D.; and Sally Schroeder, public member. Heather Adams, Assistant Attorney General, represented the state. The hearing was open to the public, pursuant to Iowa Code section 272C.6(1), and was recorded by a certified court reporter. Margaret LaMarche, Administrative Law Judge, assisted the panel in conducting the hearing and was instructed to prepare this proposed decision, in accordance with the panel's deliberations.

THE RECORD

The record includes the Statement of Charges, the Notice of Hearing, Orders Rescheduling and Continuing Hearing, Proof of Service, Request for Continuance, filed 5/29/04; Resistance; Order Denying Continuance; Motion To Amend Statement of Charges, filed 6/11/04; the testimony of the witness, and State Exhibits 1-9 (See Exhibit Index).

FINDINGS OF FACT

1. The Respondent was issued license number 23671 to practice medicine and surgery in the State of Iowa on July 1, 1983, as recorded in the permanent records in the office of the Board. The Respondent's license was renewed in 2001. (Testimony of Doug Brown; State Exhibits 2, 8)

2. On October 26, 2002, the Oklahoma State Board of Medical Licensure and Supervision denied Respondent's request for reinstatement of his Oklahoma medical license. In its Order Denying Reinstatement, the Oklahoma Board found that the Respondent had previously lost privileges at two Ohio hospitals due to quality of care concerns. The Oklahoma Board further found that the Respondent submitted false information on his reinstatement application. The Board concluded that the Respondent failed to sustain his burden of proof that he met all of the requirements for reinstatement, including but not limited to good moral character, ability to practice medicine and surgery with reasonable skill and safety, and that he is physically, mentally, professionally, and morally capable of practicing medicine and surgery in a manner reasonably acceptable to the Board.

a. In response to question J on the reinstatement application, the Respondent falsely answered "no" to the question "Have you ever been denied or had removed or suspended hospital staff privileges?" When the Oklahoma Board asked the Respondent why he gave an obviously wrong answer, he replied "I don't know why I marked there. I have no idea at all." (State Exhibit 6, p. 29)

b. In response to question L on the reinstatement application, the Respondent falsely answered "no" to the question "Have you ever been the subject of disciplinary action by a hospital, clinic, residency program, or professional school?" When asked about this response, the Respondent told the Oklahoma Board "I didn't know losing privileges is disciplinary action. I didn't know about that." (State Exhibit 6, p. 29)

c. In response to question M on the reinstatement application, the Respondent falsely answered "no" to the

question "Have you ever been named as a defendant in a civil suit (including malpractice?)"

d. The Respondent signed the reinstatement application, certifying that all statements made therein were true.

(Testimony of Doug Brown; State Exhibits 2-6)

3. The National Practitioner Data Bank has a Medical Malpractice Payment Report dated 8/3/93, indicating that a \$9,000 medical malpractice payment was made on behalf of the Respondent in settlement of a claim. This claim should have prompted the Respondent to answer "yes" to question "M" on the Oklahoma reinstatement application.

The National Practitioner Data Bank also has several adverse action reports concerning the Respondent's hospital privileges in Ohio, which should have prompted him to answer "yes" to questions "J" and "L" on the Ohio reinstatement application.

a. On 10/26/94, the Respondent was denied reappointment to the medical staff at Stouder Memorial Hospital because of quality of care concerns regarding the manner in which he completed medical records and longstanding and continuing concerns regarding his lack of availability during epidural anesthesia and on-call coverage. On 3/31/99, the Respondent filed a reply to this adverse action report denying that the report was truthful or accurate.

b. On 6/25/97, the Respondent was indefinitely required to use a scribe for all pre-operative and intra-operative reports at Piqua Memorial Medical Center. A subsequent entry on 10/8/97 reflects that the scribe requirement was lifted on 9/24/97. On 3/31/99, the Respondent filed a reply to this adverse action report stating that he was only required to have a scribe for fifty cases and never lost his privileges. The Respondent asserted that he was singled out when other physicians' had worse handwriting than his.

c. On 11/24/98, the Respondent's appointment and clinical privileges were terminated at Upper Valley Medical Center in Troy, Ohio for quality of care concerns. On 3/31/99, the Respondent filed a reply to this adverse action report denying that the report was truthful or accurate and further

stating that he had a lawsuit against the hospital that was scheduled to go to trial in January 2000.

d. On 5/16/03, the Ohio Medical Board suspended the Respondent's medical license for one year, but stayed the suspension subject to probationary terms and conditions for at least three years. This disciplinary action was based on the Oklahoma Board's action finding that the Respondent had submitted false information on his application for reinstatement.

(Testimony of Doug Brown; State Exhibit 9)

4. The Statement of Charges and original Notice of Hearing were served on the Respondent by restricted certified mail, return receipt requested, on June 7, 2003. The latest Order for Hearing was served on the Respondent by certified mail on May 21, 2004. On May 29, 2004, the Respondent wrote to the Board acknowledging receipt of the notice and requesting a continuance of the hearing. The continuance request was denied in an Order dated June 15, 2004. The Respondent did not appear for the hearing and did not ask to appear by telephone. (Order For Hearing; Proof of Service; Respondent Letter dated 5/29/04; Order Denying Continuance)

CONCLUSIONS OF LAW

I. Failure To Appear

653 IAC 12.12(1) provides that delivery of the notice of hearing together with a statement of charges constitutes the commencement of a contested case proceeding. Delivery may be executed by personal service as provided in the Iowa Rules of Civil Procedure, by restricted certified mail, return receipt requested, or by publication, as provided in the Iowa Rules of Civil Procedure.

653 IAC 12.28 provides that if a respondent, upon whom a proper notice of hearing has been served, fails to appear or participate in a contested case hearing, the presiding officer may, if no adjournment is granted, proceed with the hearing and render a decision in the absence of the party

The Respondent was properly served with the original notice of hearing and statement of charges by restricted certified mail on

June 7, 2003. He was subsequently served by certified mail with the Hearing Order rescheduling the hearing for July 6, 2004 and acknowledged receipt of the notice. The Respondent has been properly served but failed to appear for the hearing. The panel was authorized to proceed in his absence.

II. Motion To Amend Statement of Charges

On June 11, 2004, the state of Iowa filed a Motion To Amend Statement of Charges, seeking to add two additional legal counts: professional incompetency, in violation of Iowa Code section 147.55(2)(2003) and 653 IAC 12.4(2) [Count II]; and knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of medicine, in violation of Iowa Code section 147.55(3)(2003) and 653 IAC 12.4(3)(a)[Count III]. The motion was sent to the Respondent by first-class mail, but he has not filed a response. The panel denied the state's Motion to Amend the Statement of Charges because of the relatively short notice given to the Respondent. This matter had been pending for more than a year, and the Motion to Amend was not based on any new information.

III. Disciplinary Action In Another State

Iowa Code section 148.6(2)(d)(2003) provides in relevant part:

2. Pursuant to this section, the board of medical examiners may discipline a licensee who is guilty of any of the following acts or offenses:

...

d. Having the license to practice medicine and surgery, osteopathic medicine and surgery, or osteopathy revoked or suspended, or having other disciplinary action taken by a licensing authority of another state, territory, or country. A certified copy of the record or order of suspension, revocation, or disciplinary action is prima facie evidence.

The preponderance of the evidence established that on September 26, 2002, the Oklahoma State Board of Medical Licensure and Supervision took disciplinary action against the Respondent when it denied his request for reinstatement of his medical license. The Oklahoma Board's action was based on its affirmative findings that the Respondent: 1) lost privileges at two Ohio hospitals

based upon quality of care concerns; and 2) submitted false information on his reinstatement application. The Respondent never notified the Iowa Board of the disciplinary action in Oklahoma. On May 16, 2003 the Ohio State Medical Board also took disciplinary action against the Respondent based on the Oklahoma disciplinary action. The Respondent has violated Iowa Code section 148.6(2)(d)(2003) by having disciplinary action taken against him by the licensing authority of another state.

Because of the factual basis for the Oklahoma Board's action, this violation raises serious concerns about the Respondent's ability to ethically and competently practice medicine and surgery in the state of Iowa, consistent with the public health and welfare. The panel has determined that the Respondent must be required to satisfactorily address and resolve these concerns before he is permitted to practice in this state.

ORDER

IT IS THEREFORE ORDERED that the license to practice medicine and surgery in the state of Iowa, issued to Venu G. Menon, M.D., license number 23671, is hereby **INDEFINITELY SUSPENDED**.

IT IS FURTHER ORDERED that prior to seeking reinstatement of his Iowa medical license the Respondent shall successfully complete the following requirements:

A. ETHICS: Respondent shall successfully complete the Professional/Problem Based Ethics (PROBE) program sponsored by the Ethics Group, LLC, of Summit, New Jersey. Respondent shall be responsible for all costs associated with this program and shall ensure that the program sends a final report to the Board.

B. COMPETENCY EVALUATION: Respondent shall successfully complete a competency evaluation at the Center for Personalized Education for Physicians (CPEP) in Denver, Colorado. Respondent shall contact the Board to schedule the evaluation. Upon completion of the evaluation, a written report shall be provided to the Board by the evaluation program that identifies any area of deficiency in Respondent's medical practice. If areas of deficiency are identified and an educational program is recommended, Respondent shall successfully complete the educational

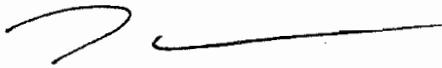
program. Respondent shall fully comply with all recommendations made by the evaluation program and the Board, including but not limited to any program of remediation. Respondent is solely responsible for all costs associated with the evaluation.

The Respondent may file an **Application for Reinstatement** of his license following his successful completion of these requirements.

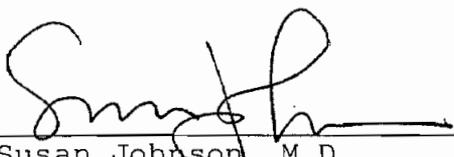
IT IS FURTHER ORDERED, in accordance with 653 IAC 12.43, that the Respondent shall pay a disciplinary hearing fee of \$75.00. In addition, the Respondent shall pay any costs certified by the executive director and reimbursable pursuant to subrule 12.43(3). All fees and costs shall be paid in the form of a check or money order payable to the state of Iowa and delivered to the department of public health, within thirty days of the issuance of a final decision.

Dated this 9th day of August, 2004.

THE PANEL:



Bruce Hughes, M.D., Chairperson
Iowa Board of Medical Examiners



Susan Johnson, M.D.



Sally Schroeder, Public Member

cc: Heather Adams, Assistant Attorney General

In accordance with 653 IAC 12.28(3), this decision becomes final agency action, unless, within 15 days after the date of

DIA No. 03DPHMB010

Page 8

notification or mailing of this decision, a motion to vacate is filed and served on all parties or an appeal of the decision on the merits is timely initiated within the time provided by 12.32(2). A motion to vacate shall state all facts relied upon by the moving party which establish that good cause existed for that party's failure to appear or participate at the contested case proceeding. Each fact so stated must be substantiated by at least one sworn affidavit or a person with personal knowledge of each such fact attached to the motion.

THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
REGULATION AND LICENSURE
STATE OF NEBRASKA

CREDENTIALING DIVISION

STATE OF NEBRASKA ex rel.,
JON BRUNING, Attorney General,

Plaintiff,

v.

VENU G. MENON, M.D.,

Defendant.

APR 12 2005

RECEIVED

69 - 050354

ORDER
ON AGREED SETTLEMENT

A PROPOSED AGREED SETTLEMENT, was filed with the Department on March 25, 2005.

ORDER

1. The Agreed Settlement is adopted, attached hereto and incorporated by reference.
2. The facts as set out in the petition are taken as true and adopted herein.
3. The parties shall comply with all of the terms of the Agreed Settlement.

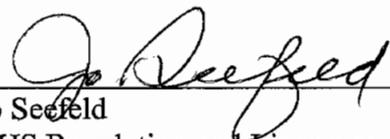
DATED this 6th day of April, 2005.




Richard A. Raymond, M.D., Director
Health and Human Services Department
Regulation and Licensure

CERTIFICATE OF SERVICE

COMES NOW the undersigned and certifies that on the 8 day of April, 2005, a copy of the foregoing ORDER ON AGREED SETTLEMENT was sent by certified United States mail, postage prepaid, return receipt requested to Venu G. Menon, M.D., 610 Boxwood Court, Troy, Ohio 45373 and by interagency mail to Bradley S. Shaff, Assistant Attorney General, 2115 State Capitol, Lincoln, Nebraska.


Jo Seefeld
HHS Regulation and Licensure
P.O. Box 95007
Lincoln, NE 68509-5007
(402) 471-0384

APR 12 2005

THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
REGULATION AND LICENSURE
STATE OF NEBRASKA

FILED

MAR 25 2005

HHS REGULATION
AND LICENSURE

STATE OF NEBRASKA ex rel. JON)
BRUNING, Attorney General,)
)
Plaintiff,)
)
vs.)
)
VENU G. MENON, M.D.,)
)
Defendant.)

AGREED SETTLEMENT

The Plaintiff and the Defendant, Venu G. Menon, M.D., in consideration of the mutual covenants and agreements contained herein, agree as follows:

1. The Defendant, Venu G. Menon, at all times relevant herein, has been the holder of a medical license (#16249), which was issued on February 14, 1983, by the Nebraska Department of Health and Human Services Regulation and Licensure ("Department").
2. The Defendant acknowledges receipt of a copy of the Petition for Disciplinary Action.
3. Before disciplinary measures may be taken against the Defendant's license, the Defendant is entitled to a hearing as provided by law. The Defendant waives the right to a hearing. The Defendant waives any right to judicial review of an order by the Department's Director who approves the terms of this Agreed Settlement.
4. No coercion, threats, or promises, other than those stated herein, were made to the Defendant to induce him to enter into this Agreed Settlement.
5. The Defendant acknowledges that he has read the Petition for Disciplinary Action filed by the Attorney General's Office. The Defendant admits the allegations of the Petition for Disciplinary Action.

6. The Defendant hereby voluntarily surrenders his medical license in the State of Nebraska for a minimum period of two (2) years in lieu of disciplinary proceedings.

7. The Defendant acknowledges that pursuant to Neb. Rev. Stat. § 71-161.11, reinstatement of the Defendant's licenses to practice as a physician in the State of Nebraska after the two year minimum of time is at the discretion of the Department and upon approval of the Board of Medicine and Surgery.

8. The Plaintiff and the Defendant consent to the Department's Director entering a final disciplinary order which finds that the allegations fo the Petition for Disciplinary Action are true and grounds exist to accept the voluntary surrender of the Defendant's medical license in lieu of disciplinary proceedings.

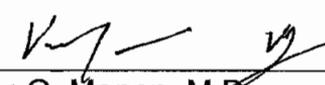
9. Any medical license now in the possession of the Defendant shall be surrendered to the Department *upon entry* of the Director's Order of Agreed Settlement.

10. The Attorney General's Office has given notice of this Agreed Settlement to the Board of Medicine and Surgery and has received their input in accordance with Neb. Rev. Stat. § 71-161.03.

11. If this Agreed Settlement is not approved by the Director, this Agreed Settlement shall become null and void and will not be admissible for any purpose at any hearing that may be held on this matter.

AGREED TO:

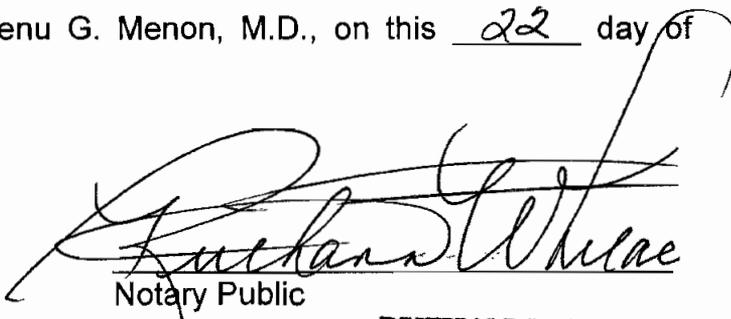
BY:



Venu G. Menon, M.D.
Defendant

State of Ohio)
County of Montgomery) ss.

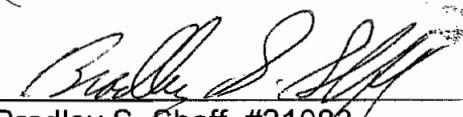
Acknowledged before me by Venu G. Menon, M.D., on this 22 day of February, 2005.


Notary Public

RUTHANN WHITACRE
NOTARY PUBLIC-STATE OF OHIO
EXP: 10-28-2007

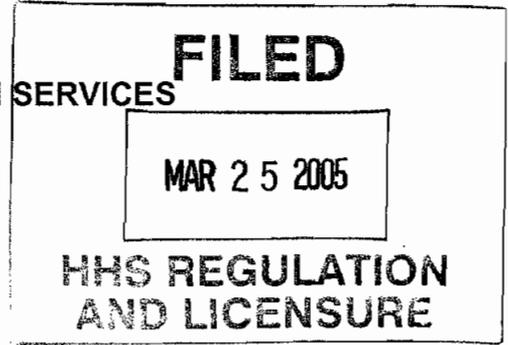
THE STATE OF NEBRASKA ex rel.
JON BRUNING, Attorney General
Plaintiff,

BY: JON BRUNING, #20351
Attorney General

BY: 
Bradley S. Shaff, #21083
Assistant Attorney General
2115 State Capitol
Lincoln, NE 68509
(402) 471-9658

Attorneys for Plaintiff.

THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
REGULATION AND LICENSURE
STATE OF NEBRASKA



STATE OF NEBRASKA ex rel. JON)
BRUNING, Attorney General,)
)
Plaintiff,)
)
vs.)
)
VENU G. MENON, M.D.,)
)
Defendant.)

PETITION FOR DISCIPLINARY
ACTION

CREDENTIALING DIVISION

APR 13 2005

RECEIVED

The Plaintiff alleges as follows:

ALLEGATIONS COMMON TO ALL CAUSES OF ACTION

1. Jurisdiction is based on Neb. Rev. Stat. §§ 71-150 and 71-1,102.
2. At all times relevant herein, the Defendant, Venu G. Menon, M.D., has been the holder of a license (#16249), which was issued on February 14, 1983, by the Nebraska Department of Health and Human Services Regulation and Licensure ("Department"), to practice as a physician.
3. The Department is the agency of the State of Nebraska authorized to enforce the provisions of the Uniform Licensing Law regulating physicians.
4. The Nebraska Board of Medicine and Surgery considered the investigation of this matter and made their recommendations to the Attorney General, which recommendations have been considered. Such matters are privileged pursuant to Neb. Rev. Stat. §§ 71-168.01(7) and 71-168.01(8).
5. Between approximately April 2000 to approximately February 2002, the Defendant was engaged in a contractual relationship with (CH) of McCook, NE, to provide professional anesthesia services.

6. On or about July 6, 2001, between approximately 12:15 p.m. and approximately 2:00 p.m., the Defendant attempted to intubate patient G.R. for administration of general anesthesia eight (8) to twelve (12) times without success. During the intubation attempts, the Defendant ordered Nurse S.B. to draw-up and administer numerous doses of succinylcholine, a paralytic agent. During the failed attempts, patient G.R.'s oxygen saturation levels dropped to between 30% and 40%. The Defendant failed to chart the orders to Nurse S.B. for the administration of succinylcholine, and failed to chart all oxygen saturation levels.

7. Between approximately April 2000 to approximately February 2002, the Defendant prescribed antibiotic medication for a patient without documenting in the patient's chart the medications prescribed or the purpose for which they were prescribed. The Defendant admitted in interviews conducted on September 10, 2003 and September 15, 2003, that he provided his girlfriend antibiotics by using the hospital prescription pads and that he did not keep any records of the medical care he provided to his girlfriend.

8. Between approximately April 2000 to approximately August 2001, the Defendant provided anesthesia services on numerous occasions for cataract procedures. In interviews of the Defendant conducted on September 10, 2003 and September 15, 2003, the Defendant admitted to re-using the same syringe on four (4) to five (5) patients each day in a three (3) to four (4) day time period. According to the Defendant, he continued the practice of reusing syringes on different patients until he was told by Nurse B. to stop.

9. Between approximately April 2000 to approximately February 2002, the Defendant failed to label each syringe he used to administer different medications during any given procedure. The Defendant admitted in interviews conducted on September 10,

2003 and September 15, 2003, that he regularly did not label the different syringes he used in each surgical case.

10. Between approximately April 2000 to approximately February 2002, the Defendant was observed by OR staff members, on more than one occasion, leaving a patient under his care, while the patient was under anesthesia, to wit:

A. On or about May 30, 2001, a surgical procedure had to be stopped when a patient started moving around. At the time, the Defendant was in the hallway outside the operating room talking with a student. The Defendant had to be asked to return to the operating room to administer more sedation so the surgical procedure could be completed.

B. On other occasions, after administering anesthesia, the Defendant left his patients in the operating room to drink coffee outside the operating room.

11. On approximately September 10, 2003 and approximately September 15, 2003, during interviews with a Department Investigator, the Defendant admitted to being approximately 20 feet away from patients under anesthesia and under his care while they were in the operating room.

12. Between approximately April 2000 to approximately February 2002, the Defendant failed to use filtered needles to withdraw medication from glass ampules.

13. Between approximately June 1, 2000 and approximately March 13, 2002, the Defendant wrote himself twenty six (26) prescriptions for Viagra.

14. On approximately September 10, 2003, the Defendant lied to a Department Investigator during an interview when he denied prescribing controlled substances for patients outside the hospital. A prescription audit obtained from F. Pharmacy showed three (3) prescriptions of Tylox (oxycodone with APAP 5/500), a controlled substance, had been written by the Defendant for patient J.B.

15. Between approximately October 1, 1994 and October 31, 1994, the Defendant's Clinical Privileges were revoked by Stouder Hospital in Troy, Ohio, for quality care concerns.

16. On or about February 21, 2002, CH informed Defendant that his contract was terminated due to the Defendant's substandard care and treatment practices.

17. The Defendant failed to report the above-described loss of privileges and termination to the Department within the mandatory thirty day reporting time period.

FIRST CAUSE OF ACTION

18. Paragraphs 1 through 17 are incorporated by reference.

19. Neb. Rev. Stat. § 71-147(10) provides that a Physician's license to practice his or her profession may be disciplined for unprofessional conduct.

20. Neb. Rev. Stat. § 71-148(19) defines unprofessional conduct as a failure to keep and maintain adequate records of treatment or service.

21. The Defendant's conduct as set out in paragraphs 6 and 7 above constitutes a failure to keep and maintain adequate records of treatment or service and is grounds for disciplinary action.

SECOND CAUSE OF ACTION

22. Paragraphs 1 through 21 are incorporated by reference.

23. Neb. Rev. Stat. § 71-147(10) provides that a Physician's license to practice his or her profession may be disciplined for unprofessional conduct.

24. Neb. Rev. Stat. § 71-148 defines unprofessional conduct as "any departure from or failure to conform to the standards of acceptable and prevailing practice of a profession or occupation or the ethics of the profession or occupation, regardless of whether a person, patient, or entity is injured...."

25. The Defendant's conduct, as alleged in paragraphs 8 through 12 constitutes a failure to conform to the standards of acceptable and prevailing practice of a profession and is grounds for disciplinary action.

THIRD CAUSE OF ACTION

26. Paragraphs 1 through 25 are incorporated by reference.

27. Neb. Rev. Stat. § 71-147(10) provides that a Physician's license to practice his or her profession may be disciplined for unprofessional conduct.

28. Neb. Rev. Stat. § 71-148 defines unprofessional conduct as "any departure from or failure to conform to the standards of acceptable and prevailing practice of a profession or occupation or the ethics of the profession or occupation, regardless of whether a person, patient, or entity is injured...."

29. American Medical Association Ethical Rule 8.19 states that "Physicians generally should not treat themselves ... Professional objectivity may be compromised when ... the physician is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered ... When treating themselves ... physicians may be inclined to treat problems that are beyond their expertise or training."

30. The Defendant's conduct, as alleged in paragraph 13, constitutes unprofessional conduct and is grounds for disciplinary action.

FOURTH CAUSE OF ACTION

31. Paragraphs 1 through 30 are incorporated by reference.

32. Neb. Rev. Stat. § 71-147(2) provides that a Physician's license to practice his or her profession may be disciplined for dishonorable conduct evidencing unfitness to meet the standards required for practice of the profession in this state.

33. The Defendant's conduct, as alleged in paragraph 14, constitutes dishonorable conduct evidencing unfitness and is grounds for disciplinary action.

FIFTH CAUSE OF ACTION

34. Paragraphs 1 through 33 are incorporated by reference.

35. Neb. Rev. Stat. § 71-147(20) provides that a Physician's license to practice his or her profession may be disciplined for failure to file a report required by Neb. Rev. Stat. § 71-168.

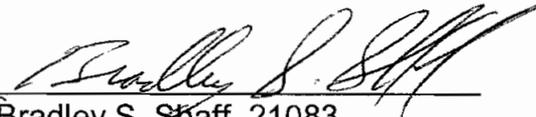
37. The Defendant's conduct, as alleged in paragraphs 15, 16 and 17, constitutes a failure to file a mandatory report within the thirty day time period and is grounds for disciplinary action.

PRAYER

WHEREFORE, the Plaintiff prays that the Chief Medical Officer set this matter for hearing, order appropriate disciplinary action pursuant to Neb. Rev. Stat. § 71-155, and tax the costs of this action to the Defendant.

STATE OF NEBRASKA, ex rel. JON
BRUNING, Attorney General,
Plaintiff,

BY: JON BRUNING, #20351
Attorney General

BY: 
Bradley S. Shaff, 21083
Assistant Attorney General
2115 State Capitol
Lincoln, NE 68509
(402) 471-3825

Attorneys for Plaintiff



State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3954 • Website: www.state.oh.us/med

May 14, 2003

Venue G. Menon, M.D.
610 Boxwood Court
Troy, OH 45373

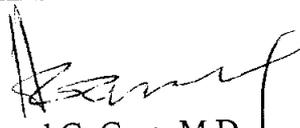
Dear Doctor Menon:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of Daniel Roberts, Attorney Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on May 14, 2003, including motions approving and confirming the Report and Recommendation as the Findings and Order of the State Medical Board of Ohio.

Section 119.12, Ohio Revised Code, may authorize an appeal from this Order. Such an appeal must be taken to the Franklin County Court of Common Pleas.

Such an appeal setting forth the Order appealed from and the grounds of the appeal must be commenced by the filing of a Notice of Appeal with the State Medical Board of Ohio and the Franklin County Court of Common Pleas. Any such appeal must be filed within fifteen (15) days after the mailing of this notice and in accordance with the requirements of Section 119.12, Ohio Revised Code.

THE STATE MEDICAL BOARD OF OHIO


Anand G. Garg, M.D.
Secretary

AGG:jam
Enclosures

CERTIFIED MAIL NO. 7000 0600 0024 5151 1497
RETURN RECEIPT REQUESTED

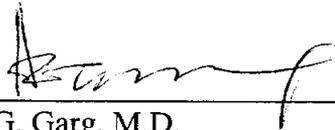
Cc: Elizabeth Y. Collis, Esq.
CERTIFIED MAIL NO. 7000 0600 0024 5151 1480
RETURN RECEIPT REQUESTED

Mailed 5/16/03

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation of Daniel Roberts, State Medical Board Attorney Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on May 14, 2003, including motions approving and confirming the Findings of Fact, Conclusions and Proposed Order of the Hearing Examiner as the Findings and Order of the State Medical Board of Ohio; constitute a true and complete copy of the Findings and Order of the State Medical Board in the Matter of Venu G. Menon, M.D., as it appears in the Journal of the State Medical Board of Ohio.

This certification is made by authority of the State Medical Board of Ohio and in its behalf.



Anand G. Garg, M.D.
Secretary

(SEAL)

May 14, 2003
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

*

*

VENU G. MENON, M.D.

*

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on May 14, 2003.

Upon the Report and Recommendation of Daniel Roberts, State Medical Board Attorney Hearing Examiner, designated in this Matter pursuant to R.C. 4731.23, a true copy of which Report and Recommendation is attached hereto and incorporated herein, and upon the approval and confirmation by vote of the Board on the above date, the following Order is hereby entered on the Journal of the State Medical Board of Ohio for the above date.

It is hereby ORDERED that:

- A. **SUSPENSION OF CERTIFICATE, STAYED; PROBATION:** The certificate of Venu G. Menon, M.D., to practice medicine and surgery in the State of Ohio shall be **SUSPENDED** for a period of one year. Such suspension is **STAYED**, subject to the following **PROBATIONARY** terms, conditions, and limitations for a period of at least three years.
1. **Obey the Law:** Dr. Menon shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in the state in which he is practicing.
 2. **Personal Appearances:** Dr. Menon shall appear in person for interviews before the full Board or its designated representative within three months of the effective date of this Order, upon the termination of probation, and/or as otherwise requested by the Board.

3. **Quarterly Declarations:** Dr. Menon shall submit quarterly declarations under penalty of Board disciplinary action or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on the first day of the third month following the month in which this Order becomes effective. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.
4. **Medical Records Course:** Before the end of the first year of probation, or as otherwise approved by the Board, Dr. Menon shall complete a course on maintaining adequate and appropriate medical records, such course to be approved in advance by the Board or its designee. Any courses taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education acquisition period(s) in which they are completed.
5. **Practice Plan:** Within thirty days of the effective date of this Order, or as otherwise determined by the Board, Dr. Menon shall submit to the Board and receive its approval for a plan of practice in Ohio. The practice plan, unless otherwise determined by the Board, shall be limited to a supervised structured environment in which Dr. Menon's activities will be directly supervised and overseen by a monitoring physician approved by the Board. Dr. Menon shall obtain the Board's prior approval for any alteration to the practice plan approved pursuant to this Order.

At the time Dr. Menon submits his practice plan, he shall also submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary or Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary or Supervising Member will give preference to a physician who practices in the same locale as Dr. Menon and who is engaged in the same or similar practice specialty.

The monitoring physician shall monitor Dr. Menon and his medical practice, and shall review Dr. Menon's patient charts. The chart review may be done on a random basis, with the frequency and number of charts reviewed to be determined by the Board.

Further, the monitoring physician shall provide the Board with reports on the monitoring of Dr. Menon and his medical practice, and on the review of Dr. Menon's patient charts. Dr. Menon shall ensure that the reports are forwarded to the Board on a quarterly basis and are received in the Board's offices no later than the due date for Dr. Menon's quarterly declaration.

In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Menon must immediately so notify the Board in writing. In addition, Dr. Menon shall make arrangements acceptable to the Board for another monitoring physician within thirty days after the previously designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the Board.

Furthermore, Dr. Menon shall ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefore.

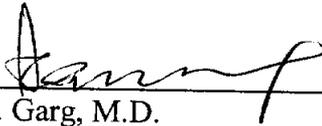
6. **Tolling of Probationary Period While Out of State:** Periods of time spent outside Ohio will not apply to the reduction of this probationary period, unless otherwise determined by motion of the Board in instances where the Board can be assured that the purposes of the probationary monitoring are being fulfilled.
 7. **Violation of Probation; Discretionary Sanction Imposed:** If Dr. Menon violates probation in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of his certificate.
 8. **Tolling of Probationary Period while Out of Compliance:** In the event Dr. Menon is found by the Secretary of the Board to have failed to comply with any provision of this Order, and is so notified of that deficiency in writing, such period(s) of noncompliance will not apply to the reduction of the probationary period.
 9. **Notification of Action Taken by Another State:** Dr. Menon shall notify the Board of any action taken against a certificate to practice held by Dr. Menon in any other state. Moreover, Dr. Menon shall provide acceptable documentation verifying the other state boards' actions.
- B. **TERMINATION OF PROBATION:** Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Menon's certificate will be fully restored.
- C. **REQUIRED REPORTING BY LICENSEE TO EMPLOYERS AND HOSPITALS:** Within thirty days of the effective date of this Order, unless otherwise determined by the Board, Dr. Menon shall provide a copy of this Order to all employers or entities with which he is under contract to provide health care services or is receiving training; and the Chief of Staff at each hospital where he has privileges or appointments. Further, Dr. Menon shall provide a copy of this

Order to all employers or entities with which he contracts to provide health care services, or applies for or receives training, and the Chief of Staff at each hospital where he applies for or obtains privileges or appointments.

- D. **REQUIRED REPORTING BY LICENSEE TO OTHER STATE LICENSING AUTHORITIES:** Within thirty days of the effective date of this Order, unless otherwise determined by the Board, Dr. Menon shall provide a copy of this Order by certified mail, return receipt requested, to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license. Dr. Menon shall also provide a copy of this Order by certified mail, return receipt requested, at time of application to the proper licensing authority of any state in which he applies for any professional license or reinstatement or restoration of any professional license. Further, Dr. Menon shall provide this Board with a copy of the return receipt as proof of notification within thirty days of receiving that return receipt, unless otherwise determined by the Board.

EFFECTIVE DATE OF ORDER: This Order shall become effective immediately upon the mailing of notification of approval by the Board.

(SEAL)


Anand G. Garg, M.D.
Secretary

May 14, 2003

Date

STATE MEDICAL BOARD
OF OHIO
2003 APR 14 P 2:02

**REPORT AND RECOMMENDATION
IN THE MATTER OF VENU G. MENON, M.D.**

The Matter of Venu G. Menon, M.D., was heard by Daniel Roberts, Attorney Hearing Examiner for the State Medical Board of Ohio, on March 18, 2003.

INTRODUCTION

I. Basis for Hearing

- A. By letter dated December 11, 2002, the State Medical Board of Ohio [Board] notified Venu G. Menon, M.D., that it had proposed to take disciplinary action against his certificate to practice medicine and surgery in this state, based on allegations that the Oklahoma State Board of Medical Licensure and Supervision [Oklahoma Board] filed an "Order Denying Reinstatement of [Dr. Menon's] Medical License."

The Board alleged that the Oklahoma Board Order constitutes "[a]ny of the following actions taken by the agency responsible for regulating the practice of medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or the limited branches of medicine in another jurisdiction, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual's license to practice; acceptance of an individual's license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand," as that clause is used in Section 4731.22(B)(22), Ohio Revised Code."

Accordingly, the Board advised Dr. Menon of his right to request a hearing in this matter. (State's Exhibit 1A)

- B. On January 10, 2003, Dr. Menon submitted a written hearing request. (State's Exhibit 1B)

II. Appearances

- A. On behalf of the State of Ohio: Jim Petro, Attorney General, by Rebecca J. Albers, Assistant Attorney General.
- B. On behalf of the Respondent: Elizabeth Y. Collis, Esq.

EVIDENCE EXAMINED

I. Testimony Heard

A. Presented by the State

Venu G. Menon, M.D., as on cross-examination

B. Presented by the Respondent

Venu G. Menon, M.D.

II. Exhibits Examined

A. Presented by the State:

1. State's Exhibits 1A-1J: Procedural exhibits.
2. State's Exhibit 2: Certified records from the Oklahoma State Board of Medical Licensure and Supervision concerning Venu G. Menon, M.D.
3. State's Exhibit 3: April 1, 2003, State's Motion for Extension of Time.

B. Presented by the Respondent:

1. Respondent's Exhibit A: Dr. Menon's curriculum vitae.
2. Respondent's Exhibit D: Copy of April 30, 2000, letter to Dr. Menon from the Board.
3. Respondent's Exhibits E through H and E1 through G1: Copies of letters of reference and support for Dr. Menon.
4. Respondent's Exhibit I: Copy of November 24, 1998, Decision and Entry Overruling Plaintiff's Motion for Preliminary Injunction in *Venu G. Menon, M.D., vs. Upper Valley Medical Center, et al.*, in the United States District Court for the Southern District of Ohio [*Menon v. UVMC*].
5. Respondent's Exhibit J: List of Witnesses and Exhibits.

C. Board Exhibits:

Board Exhibit I: Entry granting State's Motion for Extension of Time.

PROCEDURAL MATTERS

The record in this matter was held open to allow the State to submit additional documents filed in *Menon v. UVMC*. On April 8, 2003, Counsel for the State notified the Attorney Hearing Examiner and Counsel for the Respondent that she would not be submitting any additional documents. Accordingly, the record closed on April 8, 2003.

SUMMARY OF THE EVIDENCE

All exhibits and transcripts of testimony, even if not specifically mentioned, were thoroughly reviewed and considered by the Hearing Examiner prior to preparing this Report and Recommendation.

Background Information

1. Venu G. Menon, M.D., testified that he had graduated from medical school at the All India Institute of Medical Services. He further testified that immediately after graduation he had entered the Indian Army where he had served for approximately four and a half years.¹ At hearing, Dr. Menon stated that upon leaving the Indian Army he had worked as a Casualty Medical Officer in England. Subsequently, he worked in Norway, Holland and Sweden before coming to the United States in 1975. (Hearing Transcript [Tr.] at 11-14; Respondent's Exhibit [Resp. Ex.] A)
2. Dr. Menon testified that he had completed two years of anesthesiology residency training at the Albert Einstein College of Medicine in New York and has practiced anesthesiology since that time.² Dr. Menon further testified that he had joined the United States Navy in 1977 and remained on active duty until 1981. He was a reservist until 1994. While in the Navy, Dr. Menon worked in various parts of the United States. (Tr. 12-14; Resp. Ex. A)
3. Dr. Menon testified that after leaving active duty he had spent six to nine months working at the Nashville Veterans Administration [VA] Hospital. Subsequently he worked simultaneously at the University of Iowa and at a VA Hospital. He remained in Iowa until 1986 when he accepted a position with Easaw Thomas, M.D., in Troy, Ohio. Dr. Menon asserted that Dr. Thomas had promised him a partnership in his private practice if he stayed as an employee for one year. (Tr. 13, 15 and 19-20; State's Exhibit [St. Ex.] 2 at 21-25; Resp. Exs. A and I)
4. Dr. Menon testified that because of encouragement from other physicians in the area and Dr. Thomas' failure to make him a partner, he had started his own practice in August or

¹ Dr. Menon's curriculum vitae lists service in the Indian Army from 1965 until 1967. (Resp. Ex. A)

² Dr. Menon's curriculum vitae states that he completed one year of anesthesiology residency at the Albert Einstein College of Medicine and a second year at Louisville General Hospital in Louisville, Kentucky. (Resp. Ex. A)

September of 1988, after 19 months with Dr. Thomas. He noted that he had assured Dr. Thomas that he would not compete with him. Dr. Menon explained that his private practice had been primarily in anesthesia for obstetric and gynecological surgery. (Tr. 13-15 and 19; St. Ex. 2 at 21-24; Resp. Ex. A)

Dr. Menon's Oklahoma Application for Reinstatement

5. Dr. Menon testified that he had accidentally allowed his Oklahoma license to lapse by failing to renew it. Dr. Menon explained that, as he had been working full time in Ohio when he discovered his oversight, he had not requested reinstatement. However, he asserted that, during 2002, while working locum tenens, a locum tenens company had advised him that there was work available in Oklahoma and that he should renew his license there. (Tr. 32)

On April 16, 2002, Dr. Menon filed an application for reinstatement of his Oklahoma medical license. Dr. Menon testified that he had completed the Oklahoma Application himself and that at the time he had signed it he had certified that he had answered everything correctly. (Tr. 16-17 and 32-33; St. Ex. 2)

6. On June 28, 2002, Dr. Menon made a personal appearance before the Oklahoma Board, which tabled his application until they received additional information from the hospitals involved concerning Dr. Menon's loss of privileges at two hospitals in Ohio.³ (St. Ex. 2 at 9-20)

On September 19, 2002, Dr. Menon again appeared in person before the Oklahoma Board. (St. Ex. 2 at 9-20)

Dr. Menon testified that there had been many people in the room during his appearances and that he had stood at a microphone to address the Oklahoma Board members. He added that he had not been represented by legal counsel and had been "intimidated in a way" during his appearances. (Tr. 43)

The Oklahoma Board Order

7. By Order filed September 26, 2002, the Oklahoma Board denied Dr. Menon's application for reinstatement. The Oklahoma Board found that Dr. Menon had submitted false information on his reinstatement application and that he had previously lost privileges at two hospitals in Ohio based upon quality of care issues. (St. Ex. 2 at 12-13)

³ Additional information concerning Dr. Menon's loss of privileges will be found beginning at numbered paragraph 13 of the Summary of the Evidence.

The Oklahoma Board's substantive Conclusions of Law were that Dr. Menon had:

failed to sustain his burden of proof that he [had] met all requirements for reinstatement of his medical license at this time, including but not limited to the requirements that he be of good moral character, that he have the ability to practice medicine and surgery with reasonable skill and safety, and that he is physically, mentally, professionally, and morally capable of practicing medicine and surgery in a manner reasonably acceptable to the [Oklahoma] Board.

(St. Ex. 2 at 13)

Additional Information Concerning the Oklahoma Board Action

8. Dr. Menon testified at hearing in the present matter that he had answered "NO" to Question J on his Oklahoma Application, which asks "[h]ave you ever been denied or had removed or suspended hospital staff privileges?" and "[h]ave you ever surrendered hospital staff privileges while under investigation?" Dr. Menon admitted that "YES" was the correct answer. Dr. Menon explained that this answer had been an oversight on his part and that he sincerely apologizes for his error. (Tr. 33-34; St. Ex. 2 at 4)

During Dr. Menon's September 19, 2002, appearance before the Oklahoma Board the following exchange occurred between Oklahoma Board Member Tim Smalley, M.D., and Dr. Menon:

Dr. Smalley: What's your explanation for your answers to these questions that are obviously wrong?

Dr. Menon: I don't remember.

Dr. Smalley: Page 282.

Dr. Menon: Here is question is, "j", have you ever been denied or had removed or suspended hospital staff privileges. I don't know why I marked there. I have no idea at all. Then another one, have you ever been in the subject of disciplinary action. I never had any disciplinary action. Residency program, I never had any.

Dr. Smalley: By a hospital? Clinic, residency program or professional school? Your privileges were suspended.

Dr. Menon: As I told last time, I didn't know losing privileges is a disciplinary action. I didn't know about that.

(Tr. 43-44; St. Ex. 2 at 20)

9. Dr. Menon testified that he had also answered "NO" to Question L on his Oklahoma Application, which asks, "Have you ever been the subject of a disciplinary action by a hospital, clinic, residency program or professional school?" He asserted at hearing that he had believed at the time he completed his Oklahoma Application that his loss of privileges had not been a disciplinary action. He noted that the Oklahoma Board had subsequently advised him that it considered a loss of privileges a disciplinary action and he now knows that he should have answered, "YES" to that question. (Tr. 34-35; St. Ex. 2 at 4)
10. Dr. Menon testified that he had answered "YES" to Question N on his Oklahoma Application which asks "[h]ave you ever been reported to the National Practitioners Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)? (If yes, enclose a copy of the report)". He explained that he had answered "YES" because the hospital had reported the termination of his privileges to the NPDB. At hearing in the present matter, Dr. Menon admitted that he had not told the Oklahoma Board that he had lost his hospital privileges. However, Dr. Menon asserted that he had not intended to hide the fact that he had lost privileges. He explained that he had known that the Oklahoma Board would be obtaining informational letters from both the NPDB and the hospital. (Tr. 17, 33-34, 43 and 51-52; St. Ex. 2 at 4)

Upper Valley Medical Center⁴

11. Dr. Menon testified that he had had privileges at Stouder Memorial Hospital [Stouder] and Piqua Memorial Medical Center [Piqua] when he began his own practice in 1988. He noted that Stouder and Piqua had been located about ten miles apart. Dr. Menon also noted that Dr. Thomas, his former employer, had been the Chief of Anesthesiology at both hospitals. (Tr. 13, 15 and 19-20; St. Ex. 2 at 21-25; Resp. Exs. A and I)
12. Dr. Menon testified that while he had had privileges at both Piqua and Stouder he had taken call at both hospitals. He asserted that Dr. Thomas had sometimes placed him on call at both hospitals at the same time. He further asserted that when he had advised Dr. Thomas that this was a problem Dr. Thomas had not paid much attention to his complaints. (Tr. 20; St. Ex. 2 at 21-24)

During Dr. Menon's September 19, 2002, appearance before the Oklahoma Board he commented that when he was called to do an epidural at one hospital while working at the

⁴ The terms "Upper Valley Medical Center" and "UVMC" are used to represent both the new hospital building at Troy and the non-profit entity that operates or operated the Piqua, Stouder, Dettmer and Troy hospital facilities.

other he would have to finish at the first hospital before going to the other hospital. He added that he had gone back and forth between the hospitals. (St. Ex. 2 at 15 and 21-24)

Dr. Menon testified at hearing that when he was working in one hospital and received a call for the other hospital he would not be able to answer it and the hospital would have to call someone else. Dr. Menon testified that he and Dr. Thomas were the only two anesthesiologists for the hospitals. Dr. Menon pointed out that Wayne L. Fisher, D.D.S., also provided anesthesia services at UVMC. He added that Dr. Fisher and Dr. Thomas also employed nurse-anesthetists to assist them. (Tr. 20-22; St. Ex. 2 at 21-24)

Dr. Menon's 1994 Loss of Privileges at Stouder

13. By letter dated July 16, 2002, Michael J. Maiberger, Executive Vice President and Chief Operating Officer at UVMC, addressed the Oklahoma Board concerning Dr. Menon. Mr. Maiberger advised the Oklahoma Board that:

Dr. Venu G. Menon was a member of the Medical Staff of Stouder Memorial Hospital (a part of Upper Valley Medical Center) from January 28, 1987, until October 26, 1994. His appointment and privileges were terminated effective October 26, 1994. The basis of the termination was quality of care concerns regarding the manner in which Dr. Menon completed medical records; longstanding and continuing concerns regarding Dr. Menon's lack availability during epidural anesthesia and on-call coverage. Dr. Menon filed suit in the Court of Common Pleas of Miami County, Ohio opposing the termination. The court, as well as the court of appeals, upheld Upper Valley Medical Center's decision.

(St. Ex. 2 at 16-17 and 21-25)

14. At hearing in Ohio, Dr. Menon asserted that Dr. Thomas had been unhappy that Dr. Menon's private practice had been doing so well and that Dr. Thomas had begun to harass him. He further asserted that he had lost his privileges at Stouder because of Dr. Thomas' harassment. Dr. Menon elaborated that:

They had been harassing me about my handwriting. It is not legible. The pharmacist and nurses complaining that may jeopardize patient care. But probably in anesthesia, not much writing was to be done, very few, very minimal writing required. And they said that's really, that was what my belief is that.

(Tr. 15-18 and 22-23; St. Ex. 2 at 14-15 and 21-25)

15. Dr. Menon testified that he had filed a lawsuit in state court over his loss of privileges at Stouder. He added that his attorney had told him that the suit was of no use. He explained that, since he had been working at Piqua he had not ‘bothered much about’ the Stouder lawsuit. (Tr. 47-49; St. Ex. 2 at 16-19)

Dr. Menon’s Practice at Piqua, 1994-1998

16. Dr. Menon testified that his practice had been good at Piqua because many of the surgeons and patients came from Stouder to do, or to have surgery done, at Piqua because he was there. Dr. Menon testified that he had continued working at Piqua until that facility was closed. He explained that Stouder and Piqua had been closed and the new UVMC at Troy had been opened at the same time. Dr. Menon testified that he had begun working at the new UVMC when it opened. (Tr. 15-16 and 23-24; St. Ex. 2 at 21-24)

Dr. Menon’s 1998 Loss of Privileges at Piqua/UVMC⁵

17. In his July 16, 2002, letter, Mr. Maiberger advised the Oklahoma Board that:

Dr. Venu G. Menon was a member of the Medical Staff of Piqua Memorial Medical Center (a part of the Upper Valley Medical Center) from April 29, 1987, until November 24, 1998. The basis of the termination was quality of care concerns. Dr. Menon filed suit in the U.S. District Court for the Southern District of Ohio (Western Division) opposing the termination. The case is still pending.

(St. Ex. 2 at 16-17 and 25)

18. Dr. Menon asserted that in 1998 UVMC had imposed a requirement that he have a scribe. He explained that a scribe was another hospital staff member who completed his written records for him. Dr. Menon asserted that in some cases it was difficult to obtain a scribe for a particular case and, in some other cases, the scribe’s handwriting was worse than his own. Dr. Menon testified that the hospital had subsequently dropped the scribe requirement after fifty cases. (Tr. 51; St. Ex. 2 at 15 and 21-24)
19. Dr. Menon testified that he had lost his privileges at UVMC in November of 1998. He elaborated “[t]o the best of my knowledge, they didn’t renew my privileges and terminated me.” Dr. Menon testified that the basis for the UVMC termination had been the same as that at Stouder. He explained that the reasons had been “handwriting and patient care concerns.” (Tr. 24 and 30; St. Ex. 2 at 14-24)

⁵ The process by which Dr. Menon’s privileges were terminated began before the closure of Piqua. However it was not finalized until after the closure of Piqua and the opening of the new UVMC.

20. Dr. Menon testified that there had been no difference in his conduct at Stouder, Piqua and UVMC's new hospital. He stated that he had no idea why UVMC would terminate his privileges at Stouder in 1994 and wait four years to take action at Piqua/UVMC. (Tr. 52)

Dr. Menon's Federal Lawsuit

21. Dr. Menon testified that he had filed a lawsuit to appeal the decision by UVMC to terminate his privileges.⁶ Dr. Menon asserted that he does not know the status of his lawsuit. He stated that his attorney had told him that the court had ruled that some parts of the lawsuit could go forward and that other parts could not. Dr. Menon testified that his deposition has been taken and that he believes that the lawsuit may take as long as ten years to resolve. (Tr. 24-30, 47-49 and 59; St. Ex. 2 at 18 and 21-24; Resp. Ex. I)
22. On November 24, 1998, the court issued a Decision and Entry Overruling Plaintiff's Motion for Preliminary Injunction in *Menon v. UVMC*. Dr. Menon had alleged that he was entitled to injunctive relief based on claims that the defendant(s) had engaged in a

conspiracy to restrain trade in violation of § 1 of the Sherman Act, 15 U.S.C. § 1; conspiracy or unilateral action in monopolize, in violation of § 2 of the Sherman Act, 15 U.S.C. § 2; denial of civil rights in violation of 42 U.S.C. § 1981; denial of civil rights in violation of 42 U.S.C. 1983; and conspiracy in violation of 42 U.S.C. § 1985.

(Resp. Ex. I at 3)

The court noted that Dr. Menon had also alleged "bad faith breach of contract, tortuous interference with contractual relations, defamation, intentional infliction of emotional distress and discrimination." The court further noted that he had not alleged that he was entitled to injunctive relief based upon this second set of allegations. (Resp. Ex. I at 3)

Based only on the evidence presented at a preliminary injunction hearing, the court concluded that it could not find that Dr. Menon had established a strong or substantial likelihood of success on the merits of any of the preliminary injunction claims. The court observed that "the only reasonable interpretation of the evidence, as presented, is that [Dr. Menon's] privileges were terminated as an attempt by the individuals involved to address what they believed to be deficiencies in the medical care provided by [Dr. Menon]."

(Resp. Ex. I at 3-16)

⁶ *Venu G. Menon, M.D., Plaintiff, vs. Upper Valley Medical Center, et al., Defendants*, case number C-3-98-496, in the United States District Court for the Southern District of Ohio, Western Division. (Resp. Ex. I)

The court observed:

The evidence was that the decision to terminate [Dr. Menon's] privileges involved numerous levels of review. The genesis of the decision was an incident that occurred on April 18, 1997, when a patient experienced breathing problems, after [Dr. Menon] had given her an epidural, and had to be intubated. After Dr. Harbor, the director of performance improvement and utilization review at UVMC, received an anonymous occurrence report concerning the incident, she began an investigation. It was part of her normal duties to investigate such reports. Dr. Harbor then referred the matter to the Peer Review Committee, because she was not able to ascertain from the anesthesia records whether [Dr. Menon] had given the patient a test dose.

(Resp. Ex. I at 3-16)

In reciting the facts of the case in *Menon v. UVMC*, the court observed:

[Dr. Menon] presented evidence that the phrase "see attached sheet" was written on the record relating to the April 18, 1997, incident and that there were the staple holes on that record. *** According to [Dr. Menon], the quoted phrase and the staple holes indicate that an additional sheet of paper was attached to that record (which [Dr. Menon] contends supplied the missing information.)

[Dr. Menon] argues that UVMC deliberately spoliated the relevant anesthesia record, since a previously attached sheet had been removed from that record. Although an attached sheet became separated from the record, there is no evidence that this detachment occurred as the result of deliberate spoliation by UVMC or anyone else.

(Tr. 48-49; St. Ex. 2 at 18; Resp. Ex. I at 9-10)

In reciting the facts of the case in *Menon v. UVMC*, the court further observed:

In addition to the April 18, 1997, incident, the decision to terminate [Dr. Menon's] privileges was premised upon a December 2, 1997, incident, when [Dr. Menon] left the hospital after having given an epidural anesthesia to a patient. While it is not controverted that [Dr. Menon] did leave hospital on that date under those circumstances, in order to attend a continuing education seminar in San Diego, he presented evidence, during

the hearing, that a nurse had spoken to a Dr. Thomas, who had agreed to cover for [Dr. Menon]. However, Dr. Thomas did not arrive at the hospital, until more than an hour after Dr. Menon had left. [Dr. Menon] is of the opinion that the lapse of coverage was not his fault, but rather that of Dr. Thomas, the physician who had agreed to cover for him.

(Resp. Ex. I at 8)

Dr. Menon's Testimony Concerning His Malpractice Action History

23. Dr. Menon answered "NO" to question M of his Oklahoma Application which asks "[h]ave you ever been named as a defendant in a civil suit (include malpractice)?" However in the same application he stated, "I, Venu G. Menon, M.D., certify that I have been involved in a malpractice claim." (St. Ex. 2 at 4 and 8)

Dr. Menon testified that he had paid a settlement in one malpractice claim based on an allegation that he had caused psychological trauma in the course of an obstetrics case. Dr. Menon commented that he is unsure if a lawsuit was actually filed or if the matter was settled prior to a formal filing. Dr. Menon explained that he had "induced the patient with epidural, induced with a Marcaine 0.5 percent for a C-Section." He further explained that the patient had gone into convulsions upon intravascular introduction of the Marcaine. He stated that this is a known risk with Marcaine and that he had thought that she had gone into convulsions "upon overdosing in the vein." Dr. Menon asserted that the obstetrician had subsequently opined to him that the convulsions had been a hysterical manifestation. Dr. Menon stated that he had kept the patient in the Intensive Care Unit overnight and had her examined by a neurologist before her release from the hospital the following day. He asserted that the neurologist had performed an "electroencephalogram and talked to the patient, and EG didn't show any forecast of convulsions. Epileptic focus was not shown." (Tr. 22 and 45-46)

Dr. Menon testified that both the patient and her baby were all right when discharged from the hospital and that the patient had been very thankful to him at that time. However, a few weeks later he had received a letter from an attorney stating that the patient intended to file a medical malpractice lawsuit against him. Dr. Menon testified that he had settled the matter for \$9,000 and that the patient had been "quite happy" with the outcome. He further asserted that, while he did not believe that the allegations against him had anything to do with his handwriting, he was not certain if it had been a factor. (Tr. 22 and 45-46)

Information Concerning Dr. Menon's Practice After Leaving UVMC

24. Dr. Menon testified that, after losing his privileges at UVMC, he had been unemployed for six months. Subsequently, he had worked as a locum tenens in Iowa, Florida, Arizona and Nebraska. He stated that the position in Nebraska had been converted into a permanent

position and he had remained there until he had been discharged in March 2002 because of budget reductions. Subsequent to being released from the permanent position in Nebraska, Dr. Menon resumed locum tenens work in Springfield, Ohio, and Omaha, Nebraska. Dr. Menon testified that, in September 2002, he had accepted full time employment at the Dayton Outpatient Center [DOC]. Dr. Menon testified that the DOC is a private facility that has three operating rooms and offers orthopedic care as well as plastic, vascular and podiatric surgery. (Tr. 30-32 and 39-41; Resp. Ex. A)

Dr. Menon's General Testimony Concerning His Handwriting

25. During Dr. Menon's September 19, 2002, appearance before the Oklahoma Board he was asked his opinion of his own handwriting. Dr. Menon responded:

I am trying to improve on it. I write in the block letters. Still some people are difficulty reading my block letters. I'm trying to do some writing but if I write it slowly, I could manage it. I don't know what this uh ... I'm trying my best to do, write properly. Now, in the hospital I write all in block letters. That is readable.

(St. Ex. 2 at 15)

Dr. Menon testified at hearing that at the DOC he completes most records by hand rather than electronically. He added that he has not been "written up" for his handwriting. However, he admitted that some of the PA's had asked that he write more legibly. As a result he started writing in large block letters. Dr. Menon asserted that he had not had any complaints since he began writing in large block letters. (Tr. 46-51)

The Board's April 30, 2002, Letter to Dr. Menon

26. By letter dated April 30, 2002, the Board thanked Dr. Menon for his cooperation "in the review of a complaint received by the Board." The Board advised Dr. Menon "[a]fter through review, the Secretary and Supervising Member determined that no further action was required by the Board and the complaint has been closed." At hearing, Dr. Menon explained that he had spoken to an investigator from the Board about his loss of privileges and had answered all of the questions the investigator had asked. Dr. Menon asserted that he believes that the Board's April 30, 2002, letter refers to an investigation of his loss of privileges at UVMC. (Tr. 16 and 35-41; Resp. Ex. D)

Letters of Support for Dr. Menon

27. At hearing, Dr. Menon presented the following letters of support and recommendation:

- November 30, 1998, letter to the Board from Ashok G. Buddhadev, M.D., who practices Obstetrics, Gynecology and Infertility Medicine in Sidney, Ohio. He has known Dr. Menon since at least 1994.
- December 18, 1998, letter from Gerald A. Dysert, M.D., President of the Medical Executive Committee of Tover Regional Medical Center, Madisonville, Kentucky. Dr. Dysert was formerly Chief of Obstetrics and Gynecology at Stouder. He has known Dr. Menon since 1987.
- January 11, 1999, letter from Lawrence A. Gould, M.D., who practices in Sidney, Ohio, and has known Dr. Menon since 1984.
- March 6, 2003, letter to the Board from Dr. Dysert.
- March 7, 2003, letter to Dr. Menon's attorney from Dr. Gould.
- March 13, 2003, letter from Dr. Buddhadev.
- March 17, 2003, letter from C. Gill Hoang, M.D., who practices obstetrics and gynecology in Sidney Ohio.

The authors of these letters asserted that Dr. Menon is a highly competent and dedicated physician who works well with colleagues and is well liked by patients. The State did not have the opportunity to cross-examine the authors of these letters. (Tr. 41-43; Resp. Exs. E through H and E1 through G1)

Dr. Menon's licensure in Other States

28. Dr. Menon testified that he is presently licensed in Arizona, Iowa, Nebraska, Florida and Ohio. Dr. Menon stated that the Arizona Board has indicated to him that they were aware of the pending matter in Ohio. However, they have not taken any disciplinary action. Dr. Menon testified that he had received a letter from the Iowa Board inquiring about the Oklahoma Board action. He stated that he replied by letter in December 2002 and has not heard anything further from the Iowa Board. Dr. Menon testified that he has not been contacted by the Florida or Nebraska Boards concerning the Oklahoma action. (Tr. 44-45)

Additional Information

29. At hearing, Dr. Menon asked to make an additional statement to the Board. Dr. Menon explained "All I wanted to tell Mr. Roberts was, I really apologize for making the wrong marking in Oklahoma license. I had no intention of defrauding or telling a lie to the Oklahoma Board. It so happened, and I sincerely apologize for it." (Tr. 53-54)

FINDINGS OF FACT

On September 26, 2002, the Oklahoma State Board of Medical Licensure and Supervision filed an Order Denying Reinstatement of Medical License concerning Venu G. Menon, M.D. The Oklahoma Board found that Dr. Menon had submitted false information on his reinstatement application and that he had previously lost privileges at two hospitals in Ohio based upon quality of care issues.

CONCLUSIONS OF LAW

The Oklahoma Board Order concerning Venu G. Menon, M.D., as described in the Findings of Fact, constitutes “[a]ny of the following actions taken by the agency responsible for regulating the practice of medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or the limited branches of medicine in another jurisdiction, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual’s license to practice; acceptance of an individual’s license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand,” as that clause is used in Section 4731.22(B)(22), Ohio Revised Code.

* * * * *

At hearing, Venu G. Menon, M.D., elected to introduce additional information concerning his view of the underlying cause of his loss of privileges at UVMC. He also testified that he had lacked any intent to mislead the Oklahoma Board.

The notice issued to Dr. Menon by the Board on December 11, 2002, was limited to the findings of the Oklahoma Board that Dr. Menon had submitted false information on his reinstatement application and that he had previously lost privileges at two hospitals in Ohio based upon quality of care issues. The Oklahoma Board further found that he had failed to sustain his burden of proof that he had met all requirements for reinstatement of his Oklahoma medical license. The Board did not make specific allegations under the separate sections of the Ohio Revised and Administrative Codes concerning dishonesty and practice below the applicable minimal standards of care. Thus the Board is limited in the issues it may address in the present matter to the findings of the Oklahoma Board.

PROPOSED ORDER

It is hereby ORDERED that:

- A. **SUSPENSION OF CERTIFICATE, STAYED; PROBATION:** The certificate of Venu G. Menon, M.D., to practice medicine and surgery in the State of Ohio shall be **SUSPENDED** for a period of one year. Such suspension is **STAYED**, subject to the following **PROBATIONARY** terms, conditions, and limitations for a period of at least three years.
1. **Obey the Law**: Dr. Menon shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in the state in which he is practicing.
 2. **Personal Appearances**: Dr. Menon shall appear in person for interviews before the full Board or its designated representative within three months of the effective date of this Order, upon the termination of probation, and/or as otherwise requested by the Board.
 3. **Quarterly Declarations**: Dr. Menon shall submit quarterly declarations under penalty of Board disciplinary action or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on the first day of the third month following the month in which this Order becomes effective. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.
 4. **Medical Records Course**: Before the end of the first year of probation, or as otherwise approved by the Board, Dr. Menon shall complete a course on maintaining adequate and appropriate medical records, such course to be approved in advance by the Board or its designee. Any courses taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education acquisition period(s) in which they are completed.
 5. **Practice Plan**: Within thirty days of the effective date of this Order, or as otherwise determined by the Board, Dr. Menon shall submit to the Board and receive its approval for a plan of practice in Ohio. The practice plan, unless otherwise determined by the Board, shall be limited to a supervised structured environment in which Dr. Menon's activities will be directly supervised and overseen by a monitoring physician approved by the Board. Dr. Menon shall obtain the Board's prior approval for any alteration to the practice plan approved pursuant to this Order.

At the time Dr. Menon submits his practice plan, he shall also submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary or Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary or Supervising Member will give preference to a physician who practices in the same locale as Dr. Menon and who is engaged in the same or similar practice specialty.

The monitoring physician shall monitor Dr. Menon and his medical practice, and shall review Dr. Menon's patient charts. The chart review may be done on a random basis, with the frequency and number of charts reviewed to be determined by the Board.

Further, the monitoring physician shall provide the Board with reports on the monitoring of Dr. Menon and his medical practice, and on the review of Dr. Menon's patient charts. Dr. Menon shall ensure that the reports are forwarded to the Board on a quarterly basis and are received in the Board's offices no later than the due date for Dr. Menon's quarterly declaration.

In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Menon must immediately so notify the Board in writing. In addition, Dr. Menon shall make arrangements acceptable to the Board for another monitoring physician within thirty days after the previously designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Furthermore, Dr. Menon shall ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefore.

6. **Tolling of Probationary Period While Out of State**: Periods of time spent outside Ohio will not apply to the reduction of this probationary period, unless otherwise determined by motion of the Board in instances where the Board can be assured that the purposes of the probationary monitoring are being fulfilled.
7. **Violation of Probation; Discretionary Sanction Imposed**: If Dr. Menon violates probation in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of his certificate.
8. **Tolling of Probationary Period while Out of Compliance**: In the event Dr. Menon is found by the Secretary of the Board to have failed to comply with any provision of this Order, and is so notified of that deficiency in writing, such period(s) of noncompliance will not apply to the reduction of the probationary period.

9. **Notification of Action Taken by Another State:** Dr. Menon shall notify the Board of any action taken against a certificate to practice held by Dr. Menon in any other state. Moreover, Dr. Menon shall provide acceptable documentation verifying the other state boards' actions.
- B. **TERMINATION OF PROBATION:** Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Menon's certificate will be fully restored.
- C. **REQUIRED REPORTING BY LICENSEE TO EMPLOYERS AND HOSPITALS:** Within thirty days of the effective date of this Order, unless otherwise determined by the Board, Dr. Menon shall provide a copy of this Order to all employers or entities with which he is under contract to provide health care services or is receiving training; and the Chief of Staff at each hospital where he has privileges or appointments. Further, Dr. Menon shall provide a copy of this Order to all employers or entities with which he contracts to provide health care services, or applies for or receives training, and the Chief of Staff at each hospital where he applies for or obtains privileges or appointments.
- D. **REQUIRED REPORTING BY LICENSEE TO OTHER STATE LICENSING AUTHORITIES:** Within thirty days of the effective date of this Order, unless otherwise determined by the Board, Dr. Menon shall provide a copy of this Order by certified mail, return receipt requested, to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license. Dr. Menon shall also provide a copy of this Order by certified mail, return receipt requested, at time of application to the proper licensing authority of any state in which he applies for any professional license or reinstatement or restoration of any professional license. Further, Dr. Menon shall provide this Board with a copy of the return receipt as proof of notification within thirty days of receiving that return receipt, unless otherwise determined by the Board.

EFFECTIVE DATE OF ORDER: This Order shall become effective immediately upon the mailing of notification of approval by the Board.



Daniel Roberts
Attorney Hearing Examiner



State Medical Board of Ohio

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EXCERPT FROM THE DRAFT MINUTES OF MAY 14, 2003

REPORTS AND RECOMMENDATIONS

Mr. Browning announced that the Board would now consider the findings and orders appearing on the Board's agenda. He noted that the matters of Ashfaq Taj Ahmed, M.D., and Ryan Hanson, M.D., have been postponed and will be considered at the Board's June 11, 2003 meeting. Also, the Board has been unable to obtain verification of service of the Report and Recommendation in the Matter of Rezzo Spruch, M.D., so that matter is also postponed this month. He asked that Board members retain their hearing materials until such time as these matters are considered by the Board.

Mr. Browning asked whether each member of the Board had received, read, and considered the hearing record, the proposed findings, conclusions, and orders, and any objections filed in the matters of: Raleigh Shipp Callion, M.D.; Claude B. Guidi, M.D.; Sam Hill, D.O.; Venu G. Menon, M.D.; John P. Moore, III, M.D.; and Ned E. Weiner, M.D. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Ms. Sloan	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye
	Mr. Browning	- aye

Mr. Browning asked whether each member of the Board understands that the disciplinary guidelines do not limit any sanction to be imposed, and that the range of sanctions available in each matter runs from dismissal to permanent revocation. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye

Ms. Sloan	- aye
Dr. Garg	- aye
Dr. Steinbergh	- aye
Mr. Browning	- aye

Mr. Browning noted that, in accordance with the provision in Section 4731.22(F)(2), Revised Code, specifying that no member of the Board who supervises the investigation of a case shall participate in further adjudication of the case, the Secretary and Supervising Member must abstain from further participation in the adjudication of these matters.

Mr. Browning stated that if there were no objections, the Chair would dispense with the reading of the proposed findings of fact, conclusions and orders in the above matters. No objections were voiced by Board members present.

The original Reports and Recommendations shall be maintained in the exhibits section of this Journal.

.....

VENU G. MENON, M.D.

.....

DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MR. ROBERTS' PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER IN THE MATTER OF VENU G. MENON, M.D. MS. SLOAN SECONDED THE MOTION.

.....

A vote was taken on Dr. Steinbergh's motion to approve and confirm:

Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Ms. Sloan	- aye
	Dr. Garg	- abstain
	Dr. Steinbergh	- aye

The motion carried.



State Medical Board of Ohio

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December 11, 2002

Venu G. Menon, M.D.
610 Boxwood Court
Troy, Ohio 45373

Dear Doctor Menon:

In accordance with R.C. Chapter 119., you are hereby notified that the State Medical Board of Ohio intends to determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery, or to reprimand or place you on probation for one or more of the following reasons:

- (1) On or about September 26, 2002, the Oklahoma State Board of Medical Licensure and Supervision [Oklahoma Board] filed an Order Denying Reinstatement of Medical License. The Oklahoma Board findings included that you submitted false information on your reinstatement application.

A copy of the Oklahoma Order Denying Reinstatement of Medical License is attached hereto and incorporated herein.

The Oklahoma Order Denying Reinstatement of Medical License, as alleged in paragraph one (1) above, constitutes "[a]ny of the following actions taken by the agency responsible for regulating the practice of medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or the limited branches of medicine in another jurisdiction, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual's license to practice; acceptance of an individual's license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand," as that clause is used in R.C. 4731.22(B)(22).

Pursuant to R.C. Chapter 119., you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty days of the time of mailing of this notice.

You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

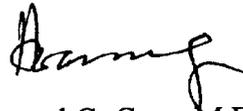
Mailed 12/12/02

In the event that there is no request for such hearing received within thirty days of the time of mailing of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery or to reprimand or place you on probation.

Please note that, whether or not you request a hearing, R.C. 4731.22(L), provides that "[w]hen the board refuses to grant a certificate to an applicant, revokes an individual's certificate to practice, refuses to register an applicant, or refuses to reinstate an individual's certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a certificate to practice and the board shall not accept an application for reinstatement of the certificate or for issuance of a new certificate."

Copies of the applicable sections are enclosed for your information.

Very truly yours,



Anand G. Garg, M.D.
Secretary

AGG/jag
Enclosures

CERTIFIED MAIL # 7000 0600 0024 5151 4436
RETURN RECEIPT REQUESTED

b. Applicant submitted false information on his reinstatement application.

4. The Board *en banc* has jurisdiction over the subject matter herein, and notice has been given in all respects as required by law and the rules of the Board.

CONCLUSIONS OF LAW

1. The Board has jurisdiction over the subject matter herein pursuant to 59 O.S. §480 et seq.
2. The Applicant has failed to sustain his burden of proof that he has met all requirements for reinstatement of his medical license at this time, including but not limited to the requirements that he be of good moral character, that he have the ability to practice medicine and surgery with reasonable skill and safety, and that he is physically, mentally, professionally, and morally capable of practicing medicine and surgery in a manner reasonably acceptable to the Board.

ORDER

IT IS THEREFORE ORDERED by the Board of Medical Licensure and Supervision as follows:

1. Applicant's request for reinstatement of his medical license shall be **DENIED**
2. A copy of this written order shall be sent to Applicant as soon as it is processed.

Dated this 26 day of September, 2002.



Gerald C. Zumwalt, M.D., Secretary
Oklahoma State Board of Medical
Licensure and Supervision

Certificate of Service

On the 3 day of ~~September~~^{Oct}, 2002, a true and correct copy of this order was mailed, postage prepaid, to the Applicant, Venu Gopal Menon, 610 Boxwood Court, Troy, OH 45373.

I do hereby certify that the above and foregoing is a true copy of the original ORDER



Janet Swindle

now on file in my office.
Witness my hand and Official Seal
of the Oklahoma State Board of
Medical Licensure and Supervision
this 15th DAY NOV 2002

